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# Appendix

# Appendix 1

## Instructions for Completion of the Wisconsin Medicaid Home Care Assessment Form

**MEDICAID HOME CARE ASSESSMENT**

Wisconsin Medicaid will return the request to the provider if the Assessment is not completed per directions that follow. Unless otherwise indicated, **all numbered items must have at least one response**.

The Home Care Assessment must be completed by a registered nurse (RN), alone or in coordination with case manager. The assessment must reflect the recipient's condition as actually observed by the RN. Every item must be completed. If an item does not apply to the recipient, print "N/A" at the item.

### 1. Provider Information

1.1 Enter the provider name exactly as it is on record with the Wisconsin Medicaid. For home health agencies, the name should match the name on the Wisconsin home health license.

1.1 Provider Name: _____

1.2 Enter your 8-digit Medicaid (MA) provider number. Personal care and home health provider numbers begin with "4" and end with "00."

1.2 Medicaid Provider Number: _____

1.3 Enter your FAX number, if any. This will allow us to contact you via FAX, if necessary.

1.3 Provider's Fax Number: _____

### 2. Recipient Information

2.1 Enter the recipient's name exactly as it appears on the recipient's Medicaid ID card. Make sure to check eligibility through the Eligibility Verification System (EVS).

2.1 Name (Last, First, Middle Initial): _____

| | |
|---|---|
| 2.2 | Enter the recipient's 10-digit Medicaid ID number exactly as it appears on the Medicaid ID card. |

2.2 Medicaid ID Number: _____

| | |
|---|---|
| 2.3 | Enter the street address, including house number and apartment number, if any, and city where recipient actually lives and receives services at the time the assessment is completed. |

2.3 Physical address where home care services are provided: _____

| | |
|---|---|
| 2.4 | Private insurance is not indicated on the Wisconsin Medicaid ID card. Providers should ask the recipient or the recipient's representative if he or she has any private insurance, including medical insurance through work or a family policy. If the insurance covers any of the home care services this recipient requires, bill the private insurance before billing Wisconsin Medicaid. |

2.4. Does the recipient have any private insurance? ☐ No ☐ Yes

(If yes, bill the private insurance before billing Medicaid. However, providers should request Medicaid prior authorization for all Medicaid covered services, including those services billed to other payers.)

| | |
|---|---|
| 2.5 | Medicare will be indicated by accessing the EVS. If Medicare is not indicated, verify this by asking the recipient or the recipient's representative if he/she has a Medicare card. If Medicare covers any of the home care services the recipient requires, bill Medicare before billing Wisconsin Medicaid. |

2.5 Does the recipient have a Medicare card? ☐ No ☐ Yes

If yes, check the applicable box: ☐ Part A only ☐ Part B only ☐ Parts A and B

| | |
|---|---|
| 2.6 | "Confined to a place of residence" means a recipient's physical medical condition or functional limitation in one or more of the areas listed in s. HFS 134.13(9)(c), Wis. Admin. Code, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent learning, which: (a) restricts the recipient's ability to leave his or her place of residence except with the aide of a supportive device, such as crutches, a cane, a wheelchair or a walker, the assistance of another person, or the use of special transportation; (b) is such that leaving the residence is medically contraindicated; or (c) requires a considerable and taxing effort to leave the home for medical services. |

2.6 Is the recipient confined to his/her residence? ☐No ☐Yes

([HFS 101.03(31), Wis. Admin. Code] A recipient does not need to be confined to the residence in order to receive Medicaid-covered home health aide or personal care worker (PCW) services. A recipient must be confined to the residence in order to receive Medicaid-covered home health nursing or home health therapy, unless the skilled service cannot be reasonably obtained through another, more appropriate provider. [Refer to the Home Health Handbook for additional information.])

| | |
|---|---|
| 2.7 | Answer the following question based on the RN's assessment of the recipient's needs, not based on the services your agency will actually be providing. If the recipient may be eligible for Medicare home health coverage, and you are not able to provide the Medicare-covered services and bill Medicare, please refer the recipient to another qualified provider. If answer is yes, a level of service box must also be checked. |

2.7 Does the recipient need any of the following skilled services? ☐No ☐Yes

☐RN ☐LPN ☐PT ☐OT ☐ST

(If a recipient is eligible for Medicare, is confined to the residence, and needs a skilled service, Medicare must be maximized before Medicaid is billed, including supplies and equipment. However, request Medicaid prior authorization for all Medicaid-covered services, including those billed to other payers.)

| | |
|---|---|
| 2.8 | Ask the recipient or the recipient's representative for the response to this question. It does not affect your ability to provide care, but may assist Wisconsin Medicaid in recovering appropriate funding from other sources. A comment may also be entered or "unknown." |

2.8 Does the recipient require home care services as the result of:

A. Motor vehicle accident: ☐No ☐Yes
B. Employment-related accident: ☐No ☐Yes
C. Other accident: ☐No ☐Yes

| | |
|---|---|
| 2.9 | Ask the recipient or the recipient's representative for the response to this question. It does not affect your ability to provide care, but will give a better picture of how the recipient's needs are being met. If the answer is yes, please cooperate with the county in coordinating care. If the answer is Yes, a funding box must also be checked. |

2.9 Does the recipient receive county funding? ☐ No ☐ Yes

If yes, complete the following:

☐ Community Options Program

☐ Medicaid waivers (CIP IA, IB, II, COP-W)

☐ Other (specify):_____

☐ Unknown

## 3. Responsible Party

| | |
|---|---|
| 3.1 | Ask the recipient or the recipient's representative for the response to this question. When the recipient is competent, the response may include a person the recipient wants involved, even though the person has no legal responsibility. It would be helpful if providers would circle the relationship of the person named. We may contact the person named if we have questions about the recipient's needs and how they are being met. |

3.1 Does the recipient have a legal guardian, person with power of attorney, or other responsible party who must be contacted, or who the recipient wants contacted, with issues regarding the recipient's care:

☐ No ☐ Yes. If yes, complete the following:

Name and relationship: _____

Address: _____

Telephone Number: _____

## 4. Other Service Providers

4.1 Ask the recipient or the recipient's representative for the response to this question. We may contact the case management agency if we have questions about the recipient's needs and how they are being met. If the answer is yes, please cooperate with the case manager in coordinating care.

4.1 Does the recipient receive case management services? ☐ No ☐ Yes

If yes, complete the following:

Case Management Agency:_____

Address:_____

Telephone Number:_____

4.2 Ask the recipient or the recipient's representative for the response to this question. We may contact the agency or individual named if we have questions about the recipient's needs and how they are being met. When the table asks for the name of the individual provider, you may enter "Unknown" if the recipient or recipient's representative is unable to provide the information. We acknowledge that the individual providers will often change. If the answer is yes, please cooperate with the other providers in coordinating care. "Name of paid individual (e.g., COP worker)" may be completed with the name of an agency. "Other provider" may be a reference to the relationship (e.g., neighbor, friend, daughter) and the address and phone number is optional for "Other provider."

4.2 Will the recipient also receive home care services from another provider?

☐ No ☐ Yes

If yes, please provide the following to assist in coordination of services.

| Type of Provider | Name | Street Address | City, State, Zip | Telephone |
|---|---|---|---|---|
| Home health or personal care | | | | |
| Paid individual (e.g., COP worker) | | N/A | N/A | N/A |
| Legally responsible spouse or parent | | N/A | N/A | |
| Unpaid household member | Enter name or relationship | N/A | N/A | N/A |
| Other provider (explain) | | | | |

(Medicaid cannot be billed for parenting or services a family member or volunteer is willing to provide free of charge.)

## 5. Scheduled Activities Outside of Residence

5.1 Ask the recipient or the recipient's representative for the response to this question. Enter the "scheduled" absences as of the date the assessment is completed, even though the recipient may not always keep the schedule. The response to this question does not affect your ability to provide care, but it gives a better picture of how the recipient functions and assists us in determining when we can contact the recipient.

5.1 Does recipient attend scheduled activities outside of the residence? ☐No ☐Yes

If yes, provide the recipient's schedule:

| Scheduled Activity | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| School | | | | | | | |
| Work | | | | | | | |
| Day Program | | | | | | | |
| Other | | | | | | | |

## 6. Living Arrangement

6.1 The purpose of this item it to determine whether the recipient's housing may limit the recipient's ability to achieve independence. For example, if the recipient cannot use a wheelchair in his or her home, even though it can be used outside of the home, less independence would be achieved.

6.1 Recipient's housing is:

☐ Accessible

☐ Not accessible to wheelchairs and assistive equipment

6.2 This information is being gathered to assist us in understanding special needs that may be associated with living arrangements. It will also be used to better coordinate care. Ask the recipient or the recipient's representative for the response to these questions.

Check "Alone..." if the recipient lives in a private residence or apartment alone.

☐ Alone (Go to 7.1)

Check "With family..." if the recipient lives in a private residence or apartment, and no other person in the home is legally responsible for the recipient.

☐ With family, friend, roommate with no legal responsibility (Go to 7.1).

Check "With legally..." if the recipient lives with a spouse or if the recipient is a minor child (under age 18) and lives with a parent. The spouse or parent cannot be paid to care for the recipient.

☐ With legally responsible adult (spouse or parent of minor child) (Go to 7.1).

Check "Foster Home" if the recipient lives with a person under a child or adult foster program. Also enter the name of the foster parent or sponsor to assist us in coordinating services. Request will be returned if box is checked and name of foster parent/sponsor is not entered.

☐ Foster Home: Name of Foster Parent/Sponsor: _____

Check "CBRF" if the recipient lives in a licensed CBRF. Also, enter the name of the CBRF to assist us in coordinating services. Note that home care services provided to residents of CBRFs are limited by the Wisconsin Administrative Code.

☐ Community-Based Residential Facility (CBRF): Name: _____

If the living arrangement for the recipient cannot be identified as one of the above choices, check this box and explain the living arrangement. Request will be returned if box is checked and the living arrangement is not specified.

☐ Other (specify): _____ (Go to 7.1)

6.3 Check the box that reflects the number of persons residing in the foster home or CBRF at the time the assessment is completed. Note that home care services provided to residents of CBRFs are limited by the Wisconsin Administrative Code. If "foster home" or "CBRF" are checked under 6.2, the request will be returned if a box is not also checked under 6.3.

6.3 If recipient resides in a foster home or CBRF, how many people reside there?

☐1-2 ☐5-8 ☐16-20
☐3-4 ☐9-15 ☐More than 20

(Wisconsin Medicaid does not cover services included in the CBRF's daily rate or personal care services in a CBRF with more than 20 beds.)

6.4 Optional. This is your opportunity to provide additional information you believe we need to know to understand the recipient's needs. Although this information does not affect the prior authorization decision tree, it may be important if your request must be referred to a nurse consultant for review.

6.4 List and explain any social, economic, or cultural factors not otherwise identified that may impact on the need for home care services or how the services are provided:

_____

_____

## 7. History of Condition



7.1 The RN must enter a brief summary of the recipient's condition, highlighting problems which directly affect the recipient's need for care. Discuss progress or lack of progress and any changes in condition which have resulted in a change of treatment or care over the past 60 days. You may attach a separate narrative, in which case you must enter "See attached narrative" here. "See attached narrative," or similar language, is also acceptable for this item if a narrative of condition is attached. If the narrative is on the HCFA 485 or 486, specify the location on the form.

7.1 Explain in the space provided, recipient's condition and any past or present problems which directly affect the delivery of home care services at this time:

_____

_____

_____

| | |
|---|---|
| 7.2 | Enter the ICD-9-CM diagnosis code, diagnosis description, and the date the diagnosis was made for all CURRENT, active diagnoses. This information must support the recipient's need for care. "See HCFA 485, #11, 12, or 13" (specify where) is also acceptable for this item. |

7.2 List each diagnosis by ICD-9-CM diagnosis code and description, and date of onset for which care is required:

_____

_____

| | |
|---|---|
| 7.3 | Based on clinical information, the RN must make an entry using professional judgement. The physician orders and prior authorization request must be consistent with this response. |

7.3 How long do you anticipate the recipient will require ongoing home care services?

☐ Indefinitely ☐ More than 12 months
☐ 12 months ☐ Less than 12 months

| | |
|---|---|
| 7.4 | Based on clinical information, the RN must make an entry using professional judgement. If the recipient may be expected to learn how to perform self-care, but not well enough to be independent, check both "Yes" and "But only somewhat." If the recipient is a child who may be expected to learn how to perform self-care in accordance with standard development stages for children, check both "Yes" and "Only at an appropriate stage." Check "No opinion" only if your experience with this recipient is too limited to make judgement at this time. A written comment, rather than a checked box, is also acceptable. |

7.4 Is there potential for the recipient to learn how to perform self-care?

☐ Yes ☐ But only somewhat, or ☐ Only at an appropriate age
☐ No
☐ No opinion

## 8. General Assessment Information

8.1 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.1. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

### 8.1 Communication

How does the recipient make his/her needs known:

- ☐ 0 = Communicates needs.
- ☐ 1 = Communicates with difficulty but can be understood.
- ☐ 2 = Communicates with sign language, symbol board, written messages, gestures, or interpreter.
- ☐ 3 = Communicates inappropriate content, makes garbled sounds.
- ☐ 4 = Does not communicate needs.
- ☐ N = Child with age appropriate communication.

8.2 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.2. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

### 8.2 Hearing

Does the recipient wear a hearing aide? ☐ No ☐ Yes

Code recipient's ability to hear with hearing aid if customarily worn:

- ☐ 0 = No hearing impairment.
- ☐ 1 = Hearing difficulty at level of conversation.
- ☐ 2 = Hears and understands only very loud sounds, e.g., has to be yelled at.
- ☐ 3 = No useful hearing, including unable to interpret audible sounds.
- ☐ 4 = Not determined.

8.3 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.3. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

8.3 Vision

Does the recipient use corrective lenses? ☐ No ☐ Yes

Code recipient's ability to see with corrective lenses if customarily worn:

☐ 0 = Has no impairment of vision.
☐ 1 = Has difficulty seeing at level of print, but may be able to read large or thick print.
☐ 2 = Has difficulty seeing obstacles in environment.
☐ 3 = Has no useful vision.
☐ 4 = Not determined.

8.4 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.4. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

8.4 Orientation

Orientation is awareness to the present environment in relation to time, place, and person:

☐ 0 = Oriented.
☐ 1 = Minor forgetfulness of:
☐ time ☐ place ☐ person ☐ medications ☐ meals
☐ 2 = Partial or intermittent periods of disorientation in:
☐ AMs ☐ PMs ☐ 2 hours or less ☐ consistently ☐ inconsistent times
☐ 3 = Totally disoriented; does not know time, place, identity.
☐ 4 = Comatose.
☐ 5 = Not determined.

## 9. Behavior/Challenging Behavior

9.1 Based on clinical information and the recipient's input, the RN must make an entry using professional judgement. Check only one box under 9.1. If NO choice appears appropriate, check the lowest box that applies and enter the information under "Comments" to describe the recipient's behavior. Only one box must be checked. If no box is checked, a comment is required. If no box is checked and no comment is entered, or if multiple boxes are checked, then the request will be returned.

9.1 Behavior

Use the code that best describes the recipient's behavior. The behavior should be considered within the context of the environment, age, and the life circumstance of the recipient before coding as a "problem." Consider unpredictability, severity, and frequency of the behavior.

- ☐ 0 = Fully cooperative.
- ☐ 1 = Needs prompts/assistance/encouragement to initiate personal care/treatment due to behavior, including noncompliance, but no assistance once care/treatment has begun.
- ☐ 2 = Needs prompts/assistance/encouragement intermittently during personal care/treatment due to behavior, including noncompliance.
- ☐ 3 = Needs consistent, ongoing support/assistance/encouragement throughout duration of personal care/ treatment due to behavior, including noncompliance.
- ☐ 4 = Exhibits one or more of the challenging behaviors under 9.2 less than daily.
- ☐ 5 = Exhibits one or more of the challenging behaviors under 9.2 daily.
- ☐ N = Age appropriate (only for children less than five years old).

Comments: _____

| | |
|---|---|
| 9.2 | Only required if box 4 or 5 is checked under 9.1. If a box is required and not checked, a comment is required. Based on clinical information, the RN must make an entry using professional judgement. After carefully reading the descriptions, check all boxes that apply. Also check the appropriate box "4" or "5" under 9.1, Behavior. You must have documented episodes of this behavior in the past 60 days. |

| | |
|---|---|
| 9.2 | Challenging Behavior |

Only complete this section if the recipient is rated a "4" or "5" under Section 9.1, Behavior. These behaviors may occur in addition to behavior(s) described under Section 9.1, Behavior.

☐ 1 Self Injurious Behavior: Engages in behavior that causes injury or has potential for causing injury to his/her own body. Examples include self-hitting, self-biting, head-banging, self-burning, self-poking, or stabbing, ingesting foreign substances, or pulling out hair.

☐ 2 Unusual/Repetitive Habits: Performs unusual stereotypic behavior that inhibits or prohibits participation in daily life activities. Examples include head-weaving, rocking, grinding teeth, spinning objects, or hand-flapping. Collects and hoards items to a point where it interferes with participation in normal daily activities.

☐ 3 Withdrawal Behavior: Excessively avoids others or situations calling for personal interaction to a point where this behavior significantly interferes with participation in normal daily activities. Examples include refusing to talk to others, remaining in his/her room for inordinate periods of time, repeatedly declining opportunities to recreate with others, extreme passivity which leads to victimization.

☐ 4 Hurtful to Others: Engages in behavior that causes physical pain to other people or to animals. Examples include hitting, biting, pinching, scratching, kicking, and inappropriate sexual contacts.

☐ 5 Socially Offensive Behavior: Behavior offensive to others or that interferes with the activity of others. Examples include spitting, urinating in inappropriate places, stealing, screaming, verbal harassment, bullying, and masturbating in public places.

☐ 6 Destruction of Property: Damages, destroys, or break things. Examples include breaking windows, lamps, or furniture; tearing clothes; setting fires; using tools or objects to damage property.

☐ 7 One-on-One Supervision for Self Preservation: Requires constant one-to-one supervision due to behavior for self preservation. *Supervision of the recipient when supervision is the only service provided at the time is not covered by Medicaid*. (For medically necessary one-to-one observation, refer to 11.2, Observation.)

Self preservation is not to be assessed for children less than four years of age because they are dependent on parents by nature of age to ensure their safety. If the child requires more assistance than an adult would typically provide for the child's age, evaluate the child.

If #7 is checked, how frequently does the recipient require one-on-one supervision for self preservation? (Check one)

☐ Less than once a month
☐ 1-4 times per month
☐ 4+ times per month, not daily
☐ Daily, but not hourly
☐ Hourly (one or more per hour during at least 8 hours per day)

Comments: _____

## 10. Activities of Daily Living (ADL)

10.1 to 10.8 Based on clinical information and the recipient's input, the RN must make an entry using professional judgement. Responses must be based on facts, not assumptions. If the RN determines that a recipient "needs" a specified service, but the recipient was able to manage without having "received" the service, do not check the box. You may explain the needs under "Comments." If the recipient disagrees with the RN's choice, state the recipient's choice under "Comments."

Check only one box in each ADL section 10.1 through 10.8. If no choice appears appropriate, enter information under "Comments" to describe the recipient's functional capacity in this area. If no box is checked, a comment is required. If no box is checked and no comment entered, or if multiple boxes are checked, the request will be returned.

### 10.1 Dressing



Dressing, such as changing from pajamas to clothes and back to pajamas. Includes application of TED or support hose, but not application of prosthetics or orthotics.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to dress. (Record for person who receives assistance to lay out clothes, fasten clothes, or whose performance must be monitored.)

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help and presence of another person during all of this activity. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

## 10.2 Grooming

Grooming, including combing or brushing (but not washing) hair, shaving, brushing/flossing teeth or cleaning dentures, nail care, applying deodorant, inserting and removing contact lenses, inserting and removing hearing aids, and feminine hygiene. Rank based on ability to perform grooming in general, not on ability to perform specific tasks.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to groom.

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

## 10.3 Bathing

Bathing or washing the recipient, whether tub, shower, or bed bath. Includes entering tub or shower, wetting, soaping, and rinsing skin and hair, exiting, drying body, and lotioning of skin.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminder or instruction, but does not need physical presence of another person at all during bath.

☐ 2 = Needs and receives help in and out of the tub, but can bathe self.

☐ 3 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 4 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 5 = Dependent on Another: Needs and receives physical help from other person to carry out washing and/or drying. Recipient is physically unable to participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

## 10.4 Eating

Eating is the process of getting food into the digestive system. Meal preparation is excluded.

- ☐ 0 = Independent: Eats without help of any kind (drinks from glass and cuts food).
- ☐ 1 = Independent: Eats without help of any kind (drinks from glass and cuts food), but requires assistance in preparing the meal.
- ☐ 2 = Needs and receives personal supervision (reminders) or programming in eating.
- ☐ 3 = Needs and receives assistance to cut meat, arrange food, butter bread, etc., at meal time.
- ☐ 4 = Needs and receives partial feeding from another person (includes drinking from a cup or observation for choking due to frequent incidents of more than once a week).
- ☐ 5 = Needs and receives total feeding from another person.
- ☐ 6 = Needs and receives tube feeding from another person.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments (include information about any special diet): _____

_____

_____

## 10.5 Transfers



Transfer is the process of moving between positions (i.e., to/from bed, chair, standing). Transfers for bathing already covered in Section 10.3.

- ☐ 0 = Independent: Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings and trapeze.
- ☐ 1 = Intermittent Supervision: Needs and receives guidance only. Requires physical presence of another person during transfer (i.e., verbal cueing, guidance).
- ☐ 2 = Needs and receives physical help from another when transferring. Recipient may participate.
- ☐ 3 = Needs and receives physical help from another or mechanical device. Recipient is unable to participate.
- ☐ 4 = Remains bedfast.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

10.6 Mobility

Mobility is the process of moving between locations (i.e., bedroom to living room).

☐ 0 = Independent: Ambulatory without a device.

☐ 1 = Needs and receives help of a device, such as cane, walker, crutch, or wheelchair, and is:
A) Independent in its use ___ B) Needs supervision (cueing or guidance) to use it ___

☐ 2 = Needs and receives physical help from another person. Includes negotiate stairs or home ramp; to lock and unlock wheelchair brakes.

☐ 3 = Needs and receives constant physical help from another person. Includes total dependence with moving wheelchair.

☐ 4 = Remains bedfast.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

10.7 Positioning

Positioning includes changing body position at a specific location (i.e., sitting up or turning over in bed).

☐ 0 = Positions self in bed or chair without help.

☐ 1 = Needs and receives occasional help from another person to sit up.

☐ 2 = Always needs and receives help from another person to sit up.

☐ 3 = Needs and receives turning and positioning.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

## 10.8 Toileting

Bowel and bladder elimination, including use of toileting equipment, such as commode, cleansing self after elimination, and adjusting clothes.

☐ 0 = Independent: Needs no supervision or physical assistance (includes recipient manages dribbling or incontinence).

☐ 1 = Intermittent Supervision: Needs and receives intermittent supervision or programming for safety or encouragement, or minor physical assistance (e.g., clothes adjustment or washing hands). No incontinence.

☐ 2 = Occasional incontinence, not more than once a week.

☐ 3 = Usually continent of bowel and bladder, but needs and receives supervision and/or physical assistance with major parts or all parts of the task, including bowel and/bladder programs and appliance (i.e., colostomy, ileostomy, urinary catheter, bed pan, incontinent product used as precaution).

☐ 4 = Incontinent of bowel and/or bladder, and is not taken to bathroom (includes person who uses incontinent product and is not toileted or catheterized).

☐ 5 = Incontinent of bowel and bladder, but is taken to a bathroom or put on bed pan every two to four hours during the day and as needed during the night.

☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

## 11. Medically Oriented Tasks

11.1 Optional. However, if a box is checked, at least one level of provider must be checked under the item. Based on clinical information and the recipient's input, the RN must make an entry using professional judgement. After carefully reading the descriptions, check all boxes that apply. Responses are to be made based on the recipient's needs, not based on what services the provider is furnishing. It may be appropriate to check both home health aide (HHA) and personal care worker (PCW) when a medically oriented task may be delegated to either, depending on availability of trained staff. The medical necessity of a medically oriented task must be established before personal care hours can be approved for reimbursement. Read the directions below.

Check all medically oriented tasks for which the recipient requires care. We expect that the recipient and family members will be taught to perform these tasks when possible. Some of the interventions listed below are routinely delegated to a home health aide (HHA) or personal care worker (PCW), while others are rarely delegated. It is the responsibility of the supervising nurse to be knowledgeable about delegation regulations under the Nurse Practice Act. Indicate the level(s) of caregiver that will provide the care.

11.1 ☐ Seizures

If this box is checked, items A, B, and C are mandatory.

A. Has the recipient had a seizure in the past 12 months? ☐No ☐Yes

B. Does the recipient require active seizure intervention for uncontrolled seizures?

☐No ☐Yes

Interventions:

☐ Take measures to protect from physical harm.
☐ Administer preselected medication.
☐ Administer sliding scale medication.
☐ Other, explain:_____

Who provides the intervention?

☐ RN/LPN ☐ HHA ☐PCW ☐Other:

C. If the recipient has a diagnosis of seizures, please complete the following:

Specific seizure type: _____

Frequency of seizures (per day, per week, or per month): _____

Date of last seizure: _____

Date seizure medication last administered: _____

11.2 ☐ Observation: Observation may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to the recipient's medical condition. For example, a recipient with active seizures not controlled by medication may require observation. Does not include supervision for physical safety of cognitively impaired or self-destructive persons (see 9.2, Challenging Behavior), or age appropriate supervision of children (i.e., babysitting).

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.3 ☐ Daily Tube Feedings:

☐ Nasogastric ☐ Gastrostomy ☐ Other: _____
☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.4 ☐ Daily Parenteral Therapy: May include intravenous medication, Hickman Catheter, or Heparin lock.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.5 ☐ Wound or Decubiti Care: May include wound or decubitus dressing and care, ostomy dressing, and warm moist packs for inflamed areas.

Wound Stage/Grade: ☐ I ☐ II ☐ III ☐ IV

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.6 ☐ Tracheostomy Care/Suctioning:

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.7 ☐ Oxygen and Respiratory Therapy: Special measures to improve respiratory function, including postural drainage, percussion, blow bottles, IPPB, respirators, suctioning, and oxygen. Excludes standby oxygen unless actually administered weekly.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.8 ☐ Catheters: Routine care is provided at least daily. Include indwelling catheters and intermittent catheterization and dressing of a suprapublic catheter.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.9 ☐ Ostomies: Routine care provided. Include colostomy, ileostomy, ureterostomy, or cystostomy.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.10 ☐ Bowel Program: Bowel program is provided at least two days per week.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.11 ☐ Therapy Program: Recipient receives assistance with therapy, including range of motion, under a therapy plan prescribed by a Physical Therapist, Occupational Therapist, or Speech and Language Pathologist within 12 months.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.12 ☐ Application/Maintenance of Prosthetics and Orthotics: Application of a prosthesis or orthosis as part of a serial splinting program or when the recipient has a demonstrated problem with frequent skin breakdowns which must be closely monitored.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.13 ☐ Complex Positioning: Positioning to reduce spasticity or positioning a recipient who would require complex repositioning when he or she has a demonstrated problem with frequent skin breakdowns; or is part of a therapy treatment program requiring specialized positioning.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.14 ☐ Complex Transfers: Complex transfers are transfers that require the use of special devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly, or when a special technique is used as part of a complex therapy program, and the recipient has no volitional movement below the neck, or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.15 ☐ Complex Feeding: Feeding with special techniques or tools when there is a potential for aspiration and physician orders state special procedures or tools must be used for safe feeding. (Thickening of liquids or small bolus of food positioned in special section of mouth.)

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.16 ☐ Glucometer Reading: Taking glucometer readings and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of readings outside of parameters established by the physician.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.17 ☐ Vital Signs: Taking vital signs and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of an exacerbation and the physician establishes parameters at which point a change in treatment may be required.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.18 ☐ Skin Care: Skin care when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Does not include PRN or prophylactic skin care, which is an activity of daily living task.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.19 ☐ Medication Assistance: Check all boxes that apply.

A. ☐ Recipient requires assistance taking medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

B. ☐ Recipient requires administration of medications. "Administer" is the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

C. ☐ Recipient requires medications to be set up because no pharmacy in the area or no family/volunteers are willing to set up the medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Comments: _____

NOTE: A separate medication list may be attached, as long as all of the requested information is provided. If a separate list is attached, enter "See attached list" under "Medication Name" on the table. If the list is part of another form (HCFA 485), specify where the medications are located on the form.

All providers must complete and update this information at least annually. In addition, providers must update this information for their own information whenever there is a change in medication. Even if your agency does not provide medication assistance or administration, you should inform your staff about medication side effects and have them report any potential side effects observed.

This section (D) is mandatory, except that the provider may refer to the attached list or HCFA 485, #10.

D. In the table, list all legend medications prescribed for the recipient at the time you complete this assessment form, OR attach a separate medication list, such as the HCFA 485. *This information is required even if your agency does not administer or assist with administration*. Include the dosage, frequency, route, and start and stop dates.

| Medication Name | Dosage/Frequency | Route | Start/Stop Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

E. If the recipient has any drug, food, or other allergies, please list them:

_____

_____

_____

11.20 Optional. Enter "N/A" if you do not have additional tasks or problems to describe. We expect "N/A" to be the most common response, but provide this space for any tasks or problems not identified elsewhere.

11.20 Other Task/Problems Not Listed:

Document any other problems which support the need for home care services and the justification for the time which is required to provide the services. Clearly document the intervention. Additional pages may be attached.

_____

_____

_____

_____

## 12. Staffing

12.1 Enter the most typical weekly schedule of staffing you expect to provide for this recipient. Enter the time your agency provides care, whether personal care, home health aide, nursing, therapist, or homemaker/companion, regardless of funding source. See examples below. A minimum of one entry is required for each level of service requested on the PA/RF unless the staffing for the level of service is sporadic and therefore only explained under 12.3. For example, if the PA/RF requests a home health nurse (HHN) visit on a weekly basis, an entry must be made next to skilled nursing. However, if the HHN visit is only monthly or every other month, it may be listed either under 12.1 or under 12.3.

To clarify the schedule, providers should also include the expected schedule of other "case sharing" agencies. If the recipient will not approve an unavoidable, temporary, schedule change, the provider can still change the schedule temporarily if no harm will come to the recipient. For example, if the PCW is ill, or delayed by bad weather, a later visit to give a bath may be inconvenient to the recipient, but not harmful, and is therefore allowable.

12.1 Anticipated Staffing: Show the scheduled times (e.g., 8 to 10 a.m.) that each agency will provide services and indicate funding source. Staffing may vary on a day-to-day basis at the convenience of the recipient. Agencies cannot vary schedule times without the approval of the recipient.

| Level of Care | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Skilled Nursing | 11-11:30 am | 11-11:30 am | 11-11:30 am | 11-11:30 am | 11-11:30 am | 11-11:30 am | 11-11:30 am |
| Home Health Aide | 7-11 am | | 7-11 am | | 7-11 am | 7-11 am | 7-11 am |
| Personal Care Worker | 11:30-3 pm<br>6-10 pm | 11:30-3 pm<br>6-10 pm | 11:30-3 pm<br>6-10 pm | 11:30-3 pm<br>6-10 pm | 11:30-3 pm<br>6-10 pm | 11:30-3 pm<br>6-10 pm | 11:30-3 pm<br>6-10 pm |
| Case Share w/ ABC | | 7-11 am<br>HH Aide | | 7-11 am<br>HH Aide | | | |
| Other (Specify) COP Worker | 3-6 pm | 3-6 pm | 3-6 pm | 3-6 pm | 3-6 pm | 3-6 pm | 3-6 pm |
| Other (Specify) | | | | | | | |

12.2 Examples of reasons why staffing may change: other caregivers either become available or not available, the frequency with which the recipient leaves the home increases or decreases, or a change in condition is anticipated which may result in staffing changes.

12.2 Is this amount of staffing expected to change within 12 months? ☐ No ☐ Yes

If yes, why? _____

12.3 Optional if 12.1 is complete. Mandatory if 12.1 does not list the scheduled visit for any level of service. In the previous schedule example at 12.1, the recipient required 24 hours of care and four hours of home health aide services were scheduled. If less than four hours of home health aide were scheduled back-to-back with personal care, it would not be granted. If less than four hours of home health aide were scheduled in the AM and personal care hours were scheduled in the PM, explain here why some of the PM care cannot be provided in the AM to maximize the aide visit. If multiple aide visits were indicated, explain here the medically oriented task performed at each visit and why all of the medically oriented tasks cannot be done at a single visit.

"N/A" may be an appropriate response.

12.3 Other clarification on staffing, such as the reason why more than one home health aide visit, or a combination of home health aide and personal care services must be provided in a day when the home health aide visit does not equal four hours for an initial or three hours for subsequent visit:

_____

_____

_____

_____

## 13. Physician Orders

CARE IS COVERED ONLY WHEN ORDERED BY A PHYSICIAN. Providers do not need to wait for signed orders to send PA requests to Wisconsin Medicaid. The unsigned orders/POC may be sent in prior to obtaining the physician's signature. However, the orders/POC must be signed by the physician and placed in the medical record within 20 days. When a case is ongoing and care will be continued, new physician's orders must be in place before the previous orders expire. Services provided without properly documented orders are subject to recoupment. Licensed and Medicare-certified home health agencies should refer to their licensing and certification requirements regarding physician orders.

## 14. Wisconsin Medicaid Reimbursement Policy

AN APPROVED AUTHORIZATION DOES NOT GUARANTEE PAYMENT. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid program payment methodology and policy. If the recipient is enrolled in a Wisconsin Medicaid contracted managed care program at the time prior authorized service is provided, Wisconsin Medicaid program reimbursement will be allowed only if the service is not covered by the managed care program.

## 15. PCW, HHA, and Travel Time Services

15.1 Enter the following information carefully. The hours and/or visits you enter here for your agency must match the hours and/or visits on your prior authorization request form (PA/RF).

15.1(A) This is the number of hours that your agency wants to provide Wisconsin Medicaid personal care, given as hours per week. It must agree with the hours requested on the PA/RF for procedure code W9900 (personal care-only agencies) or W9903 (dually certified home health and personal care agencies), without travel time included. A number or N/A is mandatory or the request will be returned to the provider.

The time must be reasonable and necessary to provide Wisconsin Medicaid-covered personal care services, which may include medically oriented tasks, activity of daily living (ADL) tasks, and incidental household tasks. Incidental household tasks must be related to medically oriented or ADL tasks and must not exceed 1/3 of the total personal care hours billed per week. The agency is responsible for monitoring the time spent on household tasks.

Regardless of the number of hours approved, providers may only bill for medically necessary covered services. Providers must maintain documentation to support the medical necessity of the services provided. Wisconsin Medicaid will review the tasks provided, including the amount of household task time, via audit.

A. Medicaid PCW care hours/week requested by this provider (from PA/RF): _____

15.1(B) This is the number of hours that another agency wants to provide Wisconsin Medicaid personal care, given as hours per week. It must agree with the hours requested on the other agency's PA/RF for procedure code W9900 or W9903. Ask the case sharing provider to give you this information from their PA/RF. A number or N/A is mandatory or the request will be returned to the provider.

B. Medicaid PCW hours/week from case sharing provider
(obtain this information from the case sharing provider): + _____

15.1(C) This is the number of hours that your agency wants to provide Wisconsin Medicaid HHA, given as hours per week. When converted from visits using the formula listed, it must agree with the number of HHA visits on your PA/RF. Authorization of separate visits of shorter duration may be allowed after RN review determines that certain time-specific tasks are medically necessary and require services to be provided in separate visits. A number or N/A is mandatory or request will be returned to provider.

Regardless of number of hours approved, providers may only bill for medically necessary, covered services. Providers must maintain documentation to support the medical necessity of the services provided. Wisconsin Medicaid will review the tasks provided via audit.

C. HHA hours/week from your agency (any payer)
(HHA initial visit may = up to 4 hours if medically necessary;
HHA subsequent visit may = up to 3 hours if medically necessary): + _____

15.1(D) This is the number of hours that another agency wants to provide Wisconsin Medicaid HHA, given as hours per week. When converted from visits using the formula listed, it must agree with the number of HHA visits on that agency's PA/RF. Ask the provider to give you this information from the PA/RF. A number or N/A is mandatory or request will be returned to provider.

D. HHA hours/week from any provider (any payer)
(HHA initial visit may = up to 4 hours if medially necessary;
HHA subsequent visit may = up to 3 hours if medically necessary): + _____



15.2(A) Add up all hours entered in 15.1, items A through D. Double-check your addition because this figure is a very important part of the PA determination.

A. TOTAL Hours: 15.1, A + B + C + D = _____

15.2(B) Enter the total number of days per week that the services indicated in 15.1(a-d) will be provided. (For example, Monday-Friday is five days; Monday-Saturday is six days, Sunday-Saturday is seven days.) A number is mandatory or request will be returned to provider.

B. Number of days care will be provided per week:
_____

15.2(C) Without additional information to support the amount of time, travel time in excess of one hour per visit, would not be considered reasonable. Refer to the Covered Services section of this handbook for further information regarding travel time. A number or N/A is mandatory or request will be returned to provider. Providers may only bill for actual travel time and must maintain documentation to support time billed.

C. PCW travel time/week requested by the provider (from PA/RF): _____

## 16. Signatures

16.1 This must be the actual signature of the RN. The agency may submit either the photocopy or the original signature for this form, but the signature on the PA/RF must be the original signature. If a case manager who is not an RN completes the assessment in coordination with an RN, the RN must review and sign the assessment. The signature date may be no earlier than 90 days prior to receipt of the assessment at Wisconsin Medicaid or a current Home Care Update must also be submitted.

16.1 As the RN, I certify that this assessment is a true, accurate, and complete reflection of this recipient's care needs. This assessment was completed by a registered nurse, or case manager in coordination with the registered nurse. Either the recipient or the recipient's responsible party was allowed to participate in the assessment. Medically necessary care will be provided in accordance with the recipient's assessed needs.

RN completing this form: _____
print

_____
signature date

16.2 The recipient or the recipient's representative has the right to participate in the preparation of a care plan. In order to attest to their participation, the recipient or the recipient's representative must sign the original assessment with 62 days of the assessment. The original signed assessment must be kept on file by the provider. If the recipient is not able to participate in the assessment, and the legal representative is not available, a family member or other person involved in the recipient's life may sign the assessment. For example, if the son is the legal representative, but the daughter regularly checks on the mother, the daughter may sign. For persons in a CBRF, the CBRF director or social worker may sign. The provider must retain the form with the original signature.

16.2 I have participated in this assessment. This is a true description of my care needs, or the recipient's care needs, when the signee is the responsible party.

Recipient or Responsible Party: _____
print

_____
signature date

(The signature is not required for submission of the prior authorization request, but must be obtained within 62 days of the assessment and maintained on file.)

# Appendix 2

## Wisconsin Medicaid Home Care Assessment Form

### 1. Provider Information

1.1 Provider Name: _____

1.2 Medicaid Provider Number: _____

1.3 Provider's Fax Number: _____

### 2. Recipient Information

2.1 Name (Last, First, Middle Initial): _____

2.2 Medicaid ID Number: _____

2.3 Physical address where home care services are provided: _____

2.4. Does the recipient have any private insurance? ☐No ☐Yes

(If yes, bill the private insurance before billing Medicaid. However, providers should request Medicaid prior authorization for all Medicaid covered services, including those services billed to other payers.)

2.5 Does the recipient have a Medicare card? ☐No ☐Yes

If yes, check the applicable box: ☐ Part A only ☐ Part B only ☐ Parts A and B

2.6 Is the recipient confined to his/her residence? ☐No ☐Yes

([HFS 101.03(31), Wis. Admin. Code] A recipient does not need to be confined to the residence in order to receive Medicaid-covered home health aide (HHA) or personal care worker (PCW) services. A recipient must be confined to the residence in order to receive Medicaid-covered home health nursing or home health therapy, unless the skilled service cannot be reasonably obtained through another, more appropriate provider. [Refer to the Home Health Handbook for additional information.])

Recipient name_____

2.7 Does the recipient need any of the following skilled services? ☐No ☐Yes

☐RN ☐LPN ☐PT ☐OT ☐ST

(If a recipient is eligible for Medicare, is confined to the residence, and needs a skilled service, Medicare must be maximized before Medicaid is billed, including supplies and equipment. However, request Medicaid prior authorization for all Medicaid-covered services, including those billed to other payers.)

2.8 Does the recipient require home care services as the result of:

A. Motor vehicle accident: ☐No ☐Yes
B. Employment-related accident: ☐No ☐Yes
C. Other accident: ☐No ☐Yes

2.9 Does the recipient receive county funding? ☐No ☐Yes

If yes, complete the following:

☐Community Options Program
☐Medicaid waivers (CIP IA, IB, II, COP-W)
☐Other (specify):_____
☐Unknown

## 3. Responsible Party

3.1 Does the recipient have a legal guardian, person with power of attorney, or other responsible party who must be contacted, or who the recipient wants contacted, with issues regarding the recipient's care: ☐No ☐Yes

If yes, complete the following:

Name and relationship: _____

Address: _____

Telephone Number:_____

Recipient name_____

## 4. Other Service Providers

4.1 Does the recipient receive case management services? ☐ No ☐ Yes

If yes, complete the following:

Case Management Agency:_____

Address:_____

Telephone Number:_____

4.2 Will the recipient also receive home care services from another provider?

☐ No ☐ Yes

If yes, please provide the following to assist in the coordination of services.

| Type of Provider | Name | Street Address | City, State, Zip | Telephone |
|---|---|---|---|---|
| Home health or personal care | | | | |
| Paid individual (e.g., COP worker) | | N/A | N/A | N/A |
| Legally responsible spouse or parent | | N/A | N/A | |
| Unpaid household members | | N/A | N/A | N/A |
| Other provider | | | | |

(Medicaid cannot be billed for parenting or services a family member or volunteer is willing to provide free of charge.)

## 5. Scheduled Activities Outside of Residence

5.1 Does recipient attend scheduled activities outside of the residence? ☐ No ☐ Yes

If yes, provide the recipient's schedule:

| Scheduled Activity | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| School | | | | | | | |
| Work | | | | | | | |
| Day Program | | | | | | | |
| Other | | | | | | | |

Recipient name_____

## 6. Living Arrangement

6.1 Recipient's housing is:

☐ Accessible
☐ Not accessible to wheelchairs and assistive equipment

6.2 Recipient's living arrangement:

☐ Alone (Go to 7.1)
☐ With family, friend, roommate with no legal responsibility (Go to 7.1)
☐ With legally responsible adult (spouse or parent of minor child) (Go to 7.1)
☐ Foster Home: Name of Foster Parent/Sponsor:
☐ Community-Based Residential Facility (CBRF): Name:
☐ Other (specify): _____ (Go to 7.1)

6.3 If recipient resides in a foster home or CBRF, how many people reside there?

☐ 1-2 ☐ 5-8 ☐ 16-20
☐ 3-4 ☐ 9-15 ☐ More than 20

(Medicaid does not cover services included in the CBRF's daily rate or personal care services in a CBRF with more than 20 beds.)



6.4 List and explain any social, economic, or cultural factors not otherwise identified that may impact on the need for home care services or how the services are provided:

_____

_____

## 7. History of Condition

7.1 Explain in the space provided, recipient's condition and any past or present problems which directly affect the delivery of home care services at this time:

_____

_____

_____

_____

Recipient name_____

_____

_____

_____

_____

_____

_____

7.2 List each diagnosis by ICD-9-CM diagnosis code and description, and date of onset for which care is required:

_____

_____

7.3 How long do you anticipate the recipient will require ongoing home care services?

☐ Indefinitely ☐ More than 12 months
☐ 12 months ☐ Less than 12 months

7.4 Is there potential for the recipient to learn how to perform self-care?

☐ Yes ☐ But only somewhat, or ☐ Only at an appropriate age
☐ No
☐ No opinion



## 8. General Assessment Information

### 8.1 Communication

How does the recipient make his/her needs known:

☐ 0 = Communicates needs.
☐ 1 = Communicates with difficulty but can be understood.
☐ 2 = Communicates with sign language, symbol board, written messages, gestures, or interpreter.
☐ 3 = Communicates inappropriate content, makes garbled sounds.
☐ 4 = Does not communicate needs.
☐ N = Child with age appropriate communication.

8.2 Hearing

Does the recipient wear a hearing aide? ☐No ☐Yes

Code recipient's ability to hear with hearing aid if customarily worn:

☐0 = No hearing impairment.
☐1 = Hearing difficulty at level of conversation.
☐2 = Hears and understands only very loud sounds, e.g., has to be yelled at.
☐3 = No useful hearing, including unable to interpret audible sounds.
☐4 = Not determined.

8.3 Vision

Does the recipient use corrective lenses? ☐No ☐Yes

Code recipient's ability to see with corrective lenses if customarily worn:

☐0 = Has no impairment of vision.
☐1 = Has difficulty seeing at level of print, but may be able to read large or thick print.
☐2 = Has difficulty seeing obstacles in environment.
☐3 = Has no useful vision.
☐4 = Not determined.



8.4 Orientation

Orientation is awareness to the present environment in relation to time, place, and person:

☐0 = Oriented.
☐1 = Minor forgetfulness of:
☐time ☐place ☐person ☐medications ☐meals
☐2 = Partial or intermittent periods of disorientation in:
☐AMs ☐PMs ☐2 hours or less ☐consistently ☐inconsistent times
☐3 = Totally disoriented; does not know time, place, identity.
☐4 = Comatose.
☐5 = Not determined.

Recipient name_____

## 9. Behavior/Challenging Behavior

### 9.1 Behavior

Use the code that best describes the recipient's behavior. The behavior should be considered within the context of the environment, age, and the life circumstance of the recipient before coding as a "problem." Consider unpredictability, severity, and frequency of the behavior.

- ☐ 0 = Fully cooperative.
- ☐ 1 = Needs prompts/assistance/encouragement to initiate personal care/treatment due to behavior, including noncompliance, but no assistance once care/treatment has begun.
- ☐ 2 = Needs prompts/assistance/encouragement intermittently during personal care/treatment due to behavior, including noncompliance.
- ☐ 3 = Needs consistent, ongoing support/assistance/encouragement throughout duration of personal care/ treatment due to behavior, including noncompliance.
- ☐ 4 = Exhibits one or more of the challenging behaviors under 9.2 less than daily.
- ☐ 5 = Exhibits one or more of the challenging behaviors under 9.2 daily.
- ☐ N = Age appropriate (only for children less than five years old).

Comments: _____

_____

### 9.2 Challenging Behavior

Only complete this section if the recipient is rated a "4" or "5" under Section 9.1, Behavior. These behaviors may occur in addition to behavior(s) described under Section 9.1, Behavior.

- ☐ 1 Self Injurious Behavior: Engages in behavior that causes injury or has potential for causing injury to his/her own body. Examples include self-hitting, self-biting, head-banging, self-burning, self-poking, or stabbing, ingesting foreign substances, or pulling out hair.
- ☐ 2 Unusual/Repetitive Habits: Performs unusual stereotypic behavior that inhibits or prohibits participation in daily life activities. Examples include head-weaving, rocking, grinding teeth, spinning objects, or hand-flapping. Collects and hoards items to a point where it interferes with participation in normal daily activities.

Recipient name_____



☐ 3 Withdrawal Behavior: Excessively avoids others or situations calling for personal interaction to a point where this behavior significantly interferes with participation in normal daily activities. Examples include refusing to talk to others, remaining in his/her room for inordinate periods of time, repeatedly declining opportunities to recreate with others, extreme passivity which leads to victimization.

☐ 4 Hurtful to Others: Engages in behavior that causes physical pain to other people or to animals. Examples include hitting, biting, pinching, scratching, kicking, and inappropriate sexual contacts.

☐ 5 Socially Offensive Behavior: Behavior offensive to others or that interferes with the activity of others. Examples include spitting, urinating in inappropriate places, stealing, screaming, verbal harassment, bullying, and masturbating in public places.

☐ 6 Destruction of Property: Damages, destroys, or break things. Examples include breaking windows, lamps, or furniture; tearing clothes; setting fires; using tools or objects to damage property.

☐ 7 One-on-One Supervision for Self Preservation: Requires constant one-to-one supervision due to behavior for self preservation. *Supervision of the recipient when supervision is the only service provided at the time is not covered by Medicaid.* (For medically necessary one-to-one observation, refer to 11.2, Observation.)

Self preservation is not to be assessed for children less than four years of age because they are dependent on parents by nature of age to ensure their safety. If the child requires more assistance than an adult would typically provide for the child's age, evaluate the child.

If #7 is checked, how frequently does the recipient require one-on-one supervision for self preservation? (Check one)

☐ Less than once a month
☐ 1-4 times per month
☐ 4+ times per month, not daily
☐ Daily, but not hourly
☐ Hourly (one or more per hour during at least 8 hours per day)

Comments: _____

_____

Recipient name_____

## 10. Activities of Daily Living (ADL)

### 10.1 Dressing

Dressing, such as changing from pajamas to clothes and back to pajamas. Includes application of TED or support hose, but not application of prosthetics or orthotics.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to dress. (Record for person who receives assistance to lay out clothes, fasten clothes, or whose performance must be monitored.)

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help and presence of another person during all of this activity. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

_____

10.2 Grooming

Grooming, including combing or brushing (but not washing) hair, shaving, brushing/flossing teeth or cleaning dentures, nail care, applying deodorant, inserting and removing contact lenses, inserting and removing hearing aids, and feminine hygiene. Rank based on ability to perform grooming in general, not on ability to perform specific tasks.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to groom.

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

_____

10.3 Bathing



Bathing or washing the recipient, whether tub, shower, or bed bath. Includes entering tub or shower, wetting, soaping, and rinsing skin and hair, exiting, drying body, and lotioning of skin.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminder or instruction, but does not need physical presence of another person at all during bath.

☐ 2 = Needs and receives help in and out of the tub, but can bathe self.

☐ 3 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 4 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 5 = Dependent on Another: Needs and receives physical help from other person to carry out washing and/or drying. Recipient is physically unable to participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

_____

Recipient name_____

## 10.4 Eating

Eating is the process of getting food into the digestive system. Meal preparation is excluded.

- ☐ 0 = Independent: Eats without help of any kind (drinks from glass and cuts food).
- ☐ 1 = Independent: Eats without help of any kind (drinks from glass and cuts food), but requires assistance in preparing the meal.
- ☐ 2 = Needs and receives personal supervision (reminders) or programming in eating.
- ☐ 3 = Needs and receives assistance to cut meat, arrange food, butter bread, etc., at meal time.
- ☐ 4 = Needs and receives partial feeding from another person (includes drinking from a cup or observation for choking due to frequent incidents of more than once a week).
- ☐ 5 = Needs and receives total feeding from another person.
- ☐ 6 = Needs and receives tube feeding from another person.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments (include information about any special diet): _____

_____

## 10.5 Transfers

Transfer is the process of moving between positions (i.e., to/from bed, chair, standing). Transfers for bathing already covered in Section 10.3.

- ☐ 0 = Independent: Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings and trapeze.
- ☐ 1 = Intermittent Supervision: Needs and receives guidance only. Requires physical presence of another person during transfer (i.e., verbal cueing, guidance).
- ☐ 2 = Needs and receives physical help from another when transferring. Recipient may participate.
- ☐ 3 = Needs and receives physical help from another or mechanical device. Recipient is unable to participate.
- ☐ 4 = Remains bedfast.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

_____

Recipient name_____

## 10.6 Mobility

Mobility is the process of moving between locations (i.e., bedroom to living room).

☐ 0 = Independent: Ambulatory without a device.

☐ 1 = Needs and receives help of a device, such as cane, walker, crutch, or wheelchair, and is:
A) Independent in its use ____. B) Needs supervision (cueing or guidance) to use it ____

☐ 2 = Needs and receives physical help from another person. Includes negotiating stairs or home ramp; to lock and unlock wheelchair brakes.

☐ 3 = Needs and receives constant physical help from another person. Includes total dependence with moving wheelchair.

☐ 4 = Remains bedfast.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

_____

## 10.7 Positioning

Positioning includes changing body position at a specific location (i.e., sitting up or turning over in bed).

☐ 0 = Positions self in bed or chair without help.

☐ 1 = Needs and receives occasional help from another person to sit up.

☐ 2 = Always needs and receives help from another person to sit up.

☐ 3 = Needs and receives turning and positioning.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

_____

Recipient name_____

10.8 Toileting

Bowel and bladder elimination, including use of toileting equipment, such as commode, cleansing self after elimination, and adjusting clothes.

☐ 0 = Independent: Needs no supervision or physical assistance (includes recipient manages dribbling or incontinence).

☐ 1 = Intermittent Supervision: Needs and receives intermittent supervision or programming for safety or encouragement, or minor physical assistance (e.g., clothes adjustment or washing hands). No incontinence.

☐ 2 = Occasional incontinence, not more than once a week.

☐ 3 = Usually continent of bowel and bladder, but needs and receives supervision and/or physical assistance with major parts or all parts of the task, including bowel and/bladder programs and appliance (i.e., colostomy, ileostomy, urinary catheter, bed pan, incontinent product used as precaution).

☐ 4 = Incontinent of bowel and/or bladder, and is not taken to bathroom (includes person who uses incontinent product and is not toileted or catheterized).

☐ 5 = Incontinent of bowel and/bladder, but is taken to a bathroom or put on bed pan every two to four hours during the day and as needed during the night.

☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

_____

## 11. Medically Oriented Tasks

Check all medically oriented tasks for which the recipient requires care. We expect that the recipient and family members will be taught to perform these tasks when possible. Some of the interventions listed below are routinely delegated to a home health aide (HHA) or personal care worker (PCW), while others are rarely delegated. It is the responsibility of the supervising nurse to be knowledgeable about delegation regulations under the Nurse Practice Act. Indicate the level(s) of caregiver that will provide the care.

11.1 ☐ Seizures

A. Has the recipient had a seizure in the past 12 months? ☐ No ☐ Yes

B. Does the recipient require active seizure intervention for uncontrolled seizures?

☐ No ☐ Yes

Interventions:

☐ Take measures to protect from physical harm.
☐ Administer preselected medication.
☐ Administer sliding scale medication.
☐ Other, explain:_____

Who provides the intervention?

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

C. If the recipient has a diagnosis of seizures, please complete the following:

Specific seizure type: _____

Frequency of seizures (Per Day, Per Week, or Per Month): _____

Date of last seizure:_____

Date seizure medication last administered: _____

11.2 ☐ Observation: Observation may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to the recipient's medical condition. For example, a recipient with active seizures not controlled by medication may require observation. Does not include supervision for physical safety of cognitively impaired or self-destructive persons (see 9.2, Challenging Behavior), or age appropriate supervision of children (i.e., babysitting).

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.3 ☐ Daily Tube Feedings:

☐ Nasogastric ☐ Gastrostomy ☐ Other: _____
☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

 Recipient name_____

11.4 ☐ Daily Parenteral Therapy: May include intravenous medication, Hickman Catheter, or Heparin lock.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.5 ☐ Wound or Decubiti Care: May include wound or decubitus dressing and care, ostomy dressing, and warm moist packs for inflamed areas.

Wound Stage/Grade: ☐ I ☐ II ☐ III ☐ IV

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.6 ☐ Tracheostomy Care/Suctioning:

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.7 ☐ Oxygen and Respiratory Therapy: Special measures to improve respiratory function, including postural drainage, percussion, blow bottles, IPPB, respirators, suctioning, and oxygen. Excludes standby oxygen unless actually administered weekly.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.8 ☐ Catheters: Routine care is provided at least daily. Include indwelling catheters and intermittent catheterization and dressing of a suprapublic catheter.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.9 ☐ Ostomies: Routine care provided. Include colostomy, ileostomy, ureterostomy, or cystostomy.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.10 ☐ Bowel Program: Bowel program is provided at least two days per week.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Recipient name_____

11.11 ☐ Therapy Program: Recipient receives assistance with therapy, including range of motion, under a therapy plan prescribed by a Physical Therapist, Occupational Therapist, or Speech and Language Pathologist within 12 months.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.12 ☐ Application/Maintenance of Prosthetics and Orthotics: Application of a prosthesis or orthosis as part of a serial splinting program or when the recipient has a demonstrated problem with frequent skin breakdowns which must be closely monitored.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.13 ☐ Complex Positioning: Positioning to reduce spasticity or positioning a recipient who would require complex repositioning when he or she has a demonstrated problem with frequent skin breakdowns; or is part of a therapy treatment program requiring specialized positioning.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.14 ☐ Complex Transfers: Complex transfers are transfers that require the use of special devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly, or when a special technique is used as part of a complex therapy program, and the recipient has no volitional movement below the neck, or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.15 ☐ Complex Feeding: Feeding with special technique or tools when there is a potential for aspiration and physician orders state special procedures or tools must be used for safe feeding. (Thickening of liquids or small bolus of food positioned in special section of mouth.)

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.16 ☐ Glucometer Reading: Taking glucometer readings and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of readings outside of parameters established by the physician.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Recipient name_____

11.17 ☐ Vital Signs: Taking vital signs and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of an exacerbation and the physician establishes parameters at which point a change in treatment may be required.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.18 ☐ Skin Care: Skin care when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Does not include PRN or prophylactic skin care, which is an activity of daily living task.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.19 ☐ Medication Assistance: Check all boxes that apply.

A. ☐ Recipient requires assistance taking medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

B. ☐ Recipient requires administration of medications. "Administer" is the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

C. ☐ Recipient requires medications to be set up because no pharmacy in the area or no family/volunteers are willing to set up the medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Comments: _____

_____

Recipient name_____

D. In the table, list all legend medications prescribed for the recipient at the time you complete this assessment form, OR attach a separate medication list, such as the HCFA 485. *This information is required even if your agency does not administer or assist with administration.* Include the dosage, frequency, route, and start and stop dates.

| Medication Name | Dosage/Frequency | Route | Start/Stop Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

E. If the recipient has any drug, food, or other allergies, please list them:

_____

_____

_____

11.20 Other Task/Problems Not Listed:

Document any other problems which support the need for home care services and the justification for the time which is required to provide the services. Clearly document the intervention. Additional pages may be attached.

_____

_____

_____

_____

12. Staffing

12.1 Anticipated Staffing: Show the scheduled times (e.g., 8:00-10:00 a.m.) that each agency will provide services and indicate funding source. Staffing may vary on a day-to-day basis at the convenience of the recipient. Agencies cannot vary schedule times without the approval of the recipient.

| Level of Care | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Skilled Nursing | | | | | | | |
| Home Health Aide | | | | | | | |
| Personal Care Worker | | | | | | | |
| Case Share w/ ABC | | | | | | | |
| Other (Specify) COP Worker | | | | | | | |
| Other (Specify) | | | | | | | |

Recipient name_____

Recipient name_____

12.2 Is this amount of staffing expected to change within 12 months? ☐ No ☐ Yes

If yes, why? _____

_____

12.3 Other clarification on staffing, such as the reason why more than one home health aide visit, or a combination of home health aide and personal care services must be provided in a day when the home health aide visit does not equal four hours for an initial or three hours for subsequent visit:

_____

_____

_____

_____

## 13. Physician's Orders

CARE IS COVERED ONLY WHEN ORDERED BY A PHYSICIAN. Providers do not need to wait for signed orders to send in prior authorization requests to Wisconsin Medicaid. The unsigned orders/POC may be sent in prior to obtaining the physician's signature. However, the orders/POC must be signed by the physician and placed in the recipient's record within 20 days. When a case is ongoing and care will be continued, new physician's orders must be in place before the previous orders expire. Services provided without properly documented orders are subject to recoupment. Licensed and Medicare-certified home health agencies should refer to their licensing and certification requirements regarding physician orders.

## 14. Wisconsin Medicaid Reimbursement Policy

AN APPROVED AUTHORIZATION DOES NOT GUARANTEE PAYMENT. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid program payment methodology and policy. If the recipient is enrolled in a Wisconsin Medicaid contracted managed care program at the time prior authorized service is provided, Wisconsin Medicaid program reimbursement will be allowed only if the service is not covered by the managed care program.

Recipient name_____

## 15. PCW, HHA, and Travel Time Services

15.1 Total Paid PCW and HHA Services:

A. Medicaid PCW care hours/week requested by this provider (from PA/RF): _____

B. Medicaid PCW hours/week from case sharing provider (obtain this information from case sharing provider): + _____

C. HHA hours/week requested from your agency (any payer) (HHA initial visit may = up to 4 hours if medically necessary; HHA subsequent visit may = up to 3 hours if medically necessary): + _____

D. HHA hours/week from any provider (any payer) (HHA initial visit may = up to 4 hours if medically necessary; HHA subsequent vist may = up to 3 hours if medically necessary): + _____

15.2 A. TOTAL Hours: 15.1, A + B + C + D = _____

B. Number of days care will be provided per week: _____

C. PCW travel time/week requested by the provider (from PA/RF): _____

## 16. Signatures

16.1 As the RN, I certify that this assessment is a true, accurate, and complete reflection of this recipient's care needs. This assessment was completed by a registered nurse or case manager in coordination with the registered nurse. Either the recipient or the recipient's responsible party was allowed to participate in the assessment. Medically necessary care will be provided in accordance with the recipient's assessed needs.

RN completing this form: _____
print

_____
signature date

16.2 I have participated in this assessment. This is a true description of my care needs, or the recipient's care needs, when the signee is the responsible party.

Recipient or Responsible Party: _____
print

_____
signature date

(The signature is not required for submission of the prior authorization request, but must be obtained within 62 days of the assessment and maintained on file.)

# Appendix 3

## Wisconsin Medicaid Home Care Assessment Update Form

1. Wisconsin Provider: Number_____ Name_____
2. Wisconsin Recipient: Number_____ Name_____

**********

**MEDICAID HOME CARE ASSESSMENT**

On _____ a Wisconsin Medicaid Home Care Assessment for the above
(Date Assessment sent to EDS)
recipient was completed and submitted to the Wisconsin Medicaid program.

Subsequently, update forms were submitted on the following dates: _____ _____ _____

I have reassessed the recipient and find that:

☐ the above dated Assessment and Updates, if any, still apply; *or*

☐ one or more item on the above dated Assessment and Updates, if any, has changed since the Assessment or Updates were completed and submitted. The pages of the Assessment with the changed Wisconsin Medicaid information, including the calendar in 12.1, are attached. (On a clean page of the Assessment form, the RN must enter the changed Wisconsin Medicaid information and initial and date to the left of each changed item. The date is the date the change was actually assessed by the RN and not the date paperwork was completed.)

_____ _____
Signature of RN completing the Assessment Update Date of Assessment Update

_____ _____
Telephone Number to contact RN with questions Fax Number

**********

A Wisconsin Medicaid Home Care Assessment must be submitted for each Wisconsin Medicaid recipient at the time of the first prior authorization request after admission.

<u>The Wisconsin Medicaid Home Care Assessment Update must be submitted whenever</u>:

1. The provider submits a Prior Authorization Request Form (PA/RF) after the initial prior authorization request and assessment is on file at Wisconsin Medicaid. (Attach Update to PA/RF. If the recipient's condition has changed since the assessment was filed, or since the last Update was submitted, also attach the amended information.)

**Continued on next page**

2. The provider submits a request to amend a prior authorization. (Attach Update and amended information to the Wisconsin Medicaid Prior Authorization Amendment Request Form.)
3. After every RN supervisory visit when there has been an improvement in condition which results in a change to the information under Sections 8-11.19 (c). This information must be submitted whether or not the change results in a change in treatment or care because it can affect the amount of care that is granted. (Attach Update and amended information to the Wisconsin Medicaid Prior Authorization Amendment Request Form.)
4. It is recommended that a complete, updated Wisconsin Medicaid Home Care Assessment Form (HCAF) be submitted every 2-3 years.

# Appendix 4

## Instructions for Completing HCFA Forms 485, 487 and 486

The HCFA-485, Home Health Certification and Plan of Treatment, is a plan of care (POC) which can be completed for Wisconsin Medicaid recipients receiving personal care worker (PCW) services. The HCFA-487, Addendum to the Plan of Treatment/Medical Update and Patient Information, may be used to provide additional documentation of any elements on the HCFA-485 or the HCFA-486, which is an update of the HCFA-485.

These forms are national forms which are available from your Medicare carrier. These forms are not available from the Wisconsin Medicaid fiscal agent. When you complete these forms to provide information to Medicare for a client who is eligible for both Medicare and Medicaid, you may submit a copy of the completed forms to Medicaid, subject to the adjustments listed below. When you use these forms for non-Medicare clients, you may:

* Use forms obtained from the Medicare intermediary and declare them on your Medicare cost report.
* Copy or print your own supply of the forms.
* Purchase the forms from another source.

## HCFA-485

### Item 1: Patient's Health Insurance (HI) Claim Number

Enter the recipient's 10-digit Medicaid identification number as found on the recipient's Forward identification card.

### Item 2: Start of Care Date

Enter the six-digit month, day, year on which covered services began, i.e., MM/DD/YY (e.g., 06/15/99). The start of care date is the first billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged.

### Item 3: Certification Period (optional)

Enter the two-digit month, day, year, MM/DD/YY (e.g., 06/15/99 - 08/15/99), which identifies the period covered by the physician's POC. The "FROM" date for the initial certification is required to match the start of care date. The "TO" date can be up to, but never more than, two calendar months later and mathematically never more than 62 days. Always repeat the "TO" date on a subsequent recertification as the next sequential "FROM" date. Services delivered on the "TO" date are covered in the next certification period.

*Example:* Initial certification "FROM" date 06/15/99
Initial certification "TO" date 08/15/99

Recertification "FROM" date 08/15/99
Recertification "TO" date 10/15/99

### Item 4: Medical Record Number (not required)

### Item 5: Provider Number

Enter the eight-digit Medicaid provider number of the billing provider.

### Item 6: Patient's Name and Address

Enter the recipient's name exactly as it appears on the recipient's Forward identification card. Enter the address of the recipient's place of residence; the street, city, state, and ZIP code must be included.

**Item 7: Provider's Name, Address and Telephone Number**
Enter the name, complete address (street, city, state, and ZIP code), and telephone number of the billing provider.

**Item 8: Date of Birth**
Enter the recipient's date of birth in MM/DD/YY format (e.g., February 3, 1955 would be 02/03/55).

**Item 9: Sex**
Enter an "X" to specify male or female.

**Item 10: Medications**
Enter all physician's orders for all medications, including the dosage, frequency and route of administration for each. Use the addendum HCFA-487 for drugs which cannot be listed on the plan of treatment. Even when a personal care worker (PCW) is not administering the medication, he or she will need to know the medications, actions, side effects, etc.

**Item 11: ICD-9-CM, Principal Diagnosis, Date**
Enter the principal diagnosis code, using the appropriate *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) diagnosis code, description, and the date (in MM/DD/YY format) of onset of the medical reason for home health care services. If a condition is chronic or long term in nature, use the date of exacerbation.

**Item 12: ICD-9-CM, Surgical Procedure, Date**
Enter the surgical procedure relevant to the care rendered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," note the ICD-9-CM code, the surgical procedure, and date (e.g., 81.62, Insertion of Austin Moore Prosthesis, 06/09/99). If a surgical procedure was not performed or is not relevant to the POC, do not leave the box blank, enter N/A. Use the addendum (HCFA-487) for additional relevant surgical procedures. At a minimum, the month and year is required to be present for the date of surgery. Use 00 if the day is unknown.

**Item 13: ICD-9-CM, Other Pertinent Diagnoses, Date**
Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established or which developed subsequently. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC. These diagnoses can be changed to reflect changes in the patient's condition.



**Item 14: Durable Medical Equipment and Supplies**
Enter all nonroutine supplies which you are supplying to the recipient.

For example, dressing changes may require use of 4 x 4s, telfa pads, kling and non-allergic tape. Catheter changes may require catheter kit and an irrigation kit as well as irrigating solutions. You need not list the exact amount of usage.

Note the item(s) of Durable Medical Equipment (DME) ordered by the physician that will be billed to Medicaid.

Enter "N/A" if no supplies or DME will be billed.

**Item 15: Safety Measures**
Enter the physician's instructions for safety measures.

**Item 16: Nutritional Requirements**
Enter the physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Record fluid needs or restrictions. Total Parenteral Nutrition (TPN) can be listed, and if more room is needed, place additional information under medications. If more space is necessary, use the HCFA-487.

**Item 17: Allergies**
Enter modifications to which the patient is allergic and other allergies the patient experiences (e.g., foods, adhesive tape, Iodine, etc.). "No known allergies" may be an appropriate response.

**Item 18a: Functional Limitations**
Check all items which describe the patient's current limitations as assessed by the physician and you.

**Item 18b: Activities Permitted**
Check the activity(ies) which the physician allows for and/or which physician orders are present.

If you check "Other" under either the "Functional Limitations" or "Activities Permitted" category, provide a narrative explanation in Item 8 of the HCFA-487.

**Item 19: Mental Status**
Check the block(s) most appropriate to describe the patient's mental status. If you check "Other," specify the conditions.

**Item 20: Prognosis**
Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, good, or excellent.

**Item 21: Orders for Discipline and Treatments**
Specify the frequency and the expected duration of the visits for each discipline ordered. State the duties/treatments to be performed by each. A discipline may be one or more of the following: registered nurse (RN), licensed practical nurse (LPN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), medical social service (MSS), home health aide (AIDE), or others (e.g., nutritionist, male orderly, respiratory therapist).

Orders must include all disciplines and treatments, even if they are not billable to Medicaid.

Frequency denotes the length of the visits, and the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks, or months.

PRN ("as needed") visits may be ordered on a POC only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is required to be specified. Open-ended, unqualified PRN visits do not constitute physician orders since neither their nature nor their frequency is specified.

**Item 22: Goals, Rehabilitation Potential, Discharge Plans**
Enter information which reflects the physician's description of the achievable goals and the patient's ability to meet them, as well as plans for care after discharge.

Rehabilitation potential addresses the patient's ability to attain his or her goals and an estimate of the time needed to achieve them. This information is pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone are not acceptable. Add descriptors.

### Item 23: Nurse's Signature and Date of Verbal Start of Care Where Applicable

This verifies that a nurse spoke to the attending physician and received verbal authorization to visit the patient.

The item is signed and dated by the nurse receiving the verbal orders. Document the initial and ongoing communications with the physician.

Enter "N/A" if the physician has signed and dated the HCFA-485 on or before the start of care date.

### Item 24: Physician's Name and Address

Print the physician's name and address. The attending physician is the physician who established the POC and who certifies and recertifies the medical necessity of the visits and/or services. Mention supplemental physicians involved in a patient's care only in Item 8 of the HCFA-487.

### Item 25: Date HHA Received, Signed POC/POT

Enter the date you received the signed POC/POT from the attending/referring physician.

### Item 26: Physician Certification

This statement serves to verify that the physician has reviewed the POC and certifies the need for the services. Cross out areas that do not apply.

### Item 27: Attending Physician's Signature, Date Signed

The attending physician signs and dates the POC within 20 working days following the start of care. Rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his patient in his absence.

Do not predate the orders for the physician, nor write the date in the field. If the physician left it blank, enter the date you received the signed POC under Item 25. Do not enter "N/A." Retain the signed POC and submit a copy with any prior authorization requests.

## HCFA-487

### Item 1: Patient's Health Insurance (HI) Claim Number

Enter the recipient's 10-digit Medicaid identification number as found on the recipient's Forward identification card.

### Item 2: Start of Care Date

For dually eligible recipients, enter the Medicare start of care date. For Medicaid recipients who are not also eligible for Medicare, enter the date of the first Medicaid billable visit.

### Item 3: Certification Period

Enter the two-digit month, day, year, MM/DD/YY (e.g., 06/15/99 - 08/15/99), which identifies the period covered by the physician's POC. The "FROM" date for the initial certification is required to match the start of care date. The "TO" date can be up to, but never more than, two calendar months later and mathematically never more than 62 days. Always repeat the "TO" date on a subsequent recertification as the next sequential "FROM" date. Services delivered on the "TO" date are covered in the next certification period.

*Example:* Initial certification "FROM" date 06/15/99
Initial certification "TO" date 08/15/99

Recertification "FROM" date 08/15/99
Recertification "TO" date 10/15/99

**Item 4: Medical Record Number** (not required)

**Item 5: Provider Number**
Enter the eight-digit Medicaid provider number of the billing provider.

**Item 6: Patient's Name**
Enter the recipient's name exactly as it appears on the recipient's Forward identification card. Enter the address of the recipient's place of residence; the street, city, state, and ZIP code must be included.

**Item 7: Provider's Name**
Enter the name and complete address (street, city, state, and ZIP code) of the billing provider.

**Item 8: Item Number** (not required)
List item numbers from the corresponding HCFA 485 for those items where additional space is needed.

**Items 9/10: Signature of Physician and Date**
If the physician's signature is not entered, the registered nurse who has accepted the verbal orders is required to sign and date the form at Items 11/12. The signed HCFA-487 must be placed in the recipient's file within 20 days of the verbal order. Services provided without properly documented physician orders are subject to recoupment.

**Items 11/12: Optional Name/Signature of Nurse/Therapist and Date**
The registered nurse accepting verbal orders is required to sign and date here.

## HCFA-486

**Item 1: Patient's Health Insurance (HI) Claim Number**
Enter the recipient's 10-digit Medicaid identification number as found on the recipient's Forward identification card.

**Item 2: Start of Care Date**
Enter the six-digit month, day, and year on which covered services began, i.e., MM/DD/YY (e.g., 06/15/99). The start of care date is the first billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged.

**Item 3: Certification Period** (optional)
Enter the two-digit month, day, year, MM/DD/YY (e.g., 06/15/99 - 08/15/99), which identifies the period covered by the physician's POC. The "FROM" date for the initial certification is required to match the start of care date. The "TO" date can be up to, but never more than, two calendar months later and mathematically never more than 62 days. Always repeat the "TO" date on a subsequent recertification as the next sequential "FROM" date. Services delivered on the "TO" date are covered in the next certification period.

*Example:* Initial certification "FROM" date 06/15/99
Initial certification "TO" date 08/15/99

Recertification "FROM" date 08/15/99
Recertification "TO" date 10/15/99

**Item 4: Medical Record Number** (not required)

**Item 5: Provider Number**
Enter the eight-digit Medicaid provider number of the billing provider.

**Item 6: Patient's Name and Address**
Enter the recipient's name exactly as it appears on the recipient's Forward identification card.

**Item 7: Provider's Name**
Enter the name of the billing provider.

**Item 8: Medicare Covered** (not required)

**Item 9: Date Physician Last Saw Patient**
Enter the date the physician last saw the patient, if this information can be obtained during the home visit. If you are unable to determine this date, enter "Unknown."

Note: It is not intended that you contact the physician's office to account for patient's visits. It is expected, but not required, for coverage that the physician who signed the POC will see the patient. However, there is no specified interval of time within which the patient is expected to be seen. Your intermediary evaluates the patient's medical condition. Visits are not denied solely on the basis that the physician does not see the patient.

**Item 10: Date Last Contacted Physician**
Note the month, day, and year (MM/DD/YY e.g., 12/10/99) of your most recent physician contact (verbal or written) regarding the status or problems encountered with the patient during the last 60 days. Briefly state the purpose of your contact under Item 15 (Updated Information).

**Item 11: Is Patient Receiving Care in a 1861 (J) (1) Skilled Nursing Facility or Equivalent**
Check the appropriate block. Since a requirement for eligibility for the home health benefit is that services be provided at the patient's residence, if the patient is residing in a nursing home, the facility cannot be considered the patient's residence.

**Item 12: Certification/Recertification/Modified**
Check one of the blocks to identify this POC as a certification, recertification, or modification. Modified refers to the HCFA-486 used to report changes during a certification period.



**Item 13: Dates of Last Inpatient Stay**
Enter the admission and discharge dates (MM/DD/YY e.g., 10/02/99 - 10/12/99) of the last inpatient stay relevant to the care provided. Enter "N/A" if not applicable.

**Item 14: Type of Facility**
Identify the type of facility. If Item 13 has been completed, recording a stay relevant to care being provided, this item must also be completed. Enter "N/A" if not applicable.

The responses for the locator are:

A = Acute Hospital
S = SNF
R = Rehabilitation Hospital
I = ICF
O = Other
U = Unknown

**Item 15: Updated Information (New Orders/Treatments/Clinical Facts/Summary From Each Discipline)**

Record any new orders, treatments or changes and associated date(s) from the time the HCFA-485 is completed, to the time the HCFA-486 is completed.

On certifications, enter the clinical findings of the initial assessment visit for all disciplines involved in the care plan. Describe the clinical facts about the patient that require skilled home health services. Include specific dates.

On recertification, record significant clinical findings for each discipline incorporating all symptoms and changes in the patient's condition during the last 60 days of service. Include specific dates. Document progress or nonprogress for each discipline.

Include any pertinent information on a patient's inpatient stay and the purpose of any agency contact with the physicians, if applicable.

**Item 16: Functional Limitations (Expand from HCFA-485 and Level of ADL) Reason Homebound/ Prior Functional Status**

Provide a narrative description of the patient's prior functional status and current limitations and activities permitted. Elaborate on the information in the checklist (HCFA-485 Items 18a and 18b) and provide any other information needed to describe the patient. Clearly reflect the type and scope of assistance needed. Include a brief statement of why the patient is homebound. Include a description of the home environment if it is relevant to the homebound determination (e.g., patient lives in a third floor walk-up apartment and is recovering from congestive heart failure).

**Item 17: Supplementary POC on File From Physician Other Than the Referring Physician (If yes, Specify Giving Goals/Rehabilitation Potential/Discharge Plan)**

Provide this information if more than one POC is being used to provide services. If so, document the specialty, type of service, duties, goals, rehabilitation potential, and discharge plans here or attach a copy of the written plan to the HCFA-486. Give the reasons necessitating a supplemental plan.

**Item 18: Unusual Home/Social Environment**

Use this block to include information which enhances the reviewer's concept of the home situation and helps to justify the need for services in the home (e.g., patient lives with retarded son, who is unable to provide any assistance or to comprehend instructions). The information may explain the rationale for medical social services by documenting the problems which are, or will be, an impediment to the effective treatment of the patient's medical condition or rate of recovery.

**Item 19: Indicate Any Time You Made a Visit and Patient was not Home, and Reasons Why Patient was Gone, if Ascertainable**

Indicate when and why this occurred (e.g., 11/03/99 - patient was taken to the emergency room for evaluation and treatment after a fall at home).

**Item 20: Specify Any Known Medical and/or Nonmedical Reasons Why the Patient Regularly Leaves Home and Frequency of Occurence**

Obtain information from the patient, family or caretaker for the patient's absences from the home and whether they were for medical or nonmedical reasons (e.g., the patient goes to the barber shop once a month and to the doctor twice a month).

**Item 21: Signature of Nurse of Therapist Completing or Reviewing Form/Date (Month, Day, Year)**

The nurse or therapist responsible for the completion of the form, or a nonclerical agency representative or supervisor responsible for the review, signs and dates the form.

# Appendix 5

## HCFA-485 Form

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

### HOME HEALTH CERTIFICATION AND PLAN OF CARE

| 1. Patient's HI Claim No. | 2. Start Of Care Date | 3. Certification Period From: To: | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| | | | | |

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐M ☐F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

| | | |
|---|---|---|
| 11. ICD-9-CM | Principal Diagnosis | Date |
| 12. ICD-9-CM | Surgical Procedure | Date |
| 13. ICD-9-CM | Other Pertinent Diagnoses | Date |

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

| 23. Nurse's Signature and Date of Verbal SOC Where Applicable: | 25. Date HHA Received Signed POT |
|---|---|
| 24. Physician's Name and Address | 26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I hav authorized the services on this plan of care and will periodically review the plan. |
| 27. Attending Physician's Signature and Date Signed | 28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. |

Form HCFA-485 (C-3) (02-94) (Print Aligned)

PROVIDER

# Appendix 6

## HCFA-486 Form

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

**MEDICAL UPDATE AND PATIENT INFORMATION**

| 1. Patient's HI Claim No. | 2. SOC Date | 3. Certification Period From: To: | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| | | | | |

6. Patient's Name and Address

7. Provider's Name

8. Medicare Covered: ☐ Y ☐ N

9. Date Physician Last Saw Patient:

10. Date Last Contacted Physician:

11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? ☐ Y ☐ N ☐ Do Not Know

12. ☐ Certification ☐ Recertification ☐ Modified

13. Dates of Last Inpatient Stay: Admission Discharge

14. Type of Facility:

15. Updated information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

16. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

17. Supplementary Plan of Care of File from Physician Other than Referring Physician: ☐ Y ☐ N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

18. Unusual Home/Social Environment

19. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

20. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

21. Nurse or Therapist Completing or Reviewing Form

Date (Mo., Day, Yr.)

**PROVIDER**

Form HCFA-486 (C3) (02-94)

# Appendix 7

## HCFA-487 Form

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

**ADDENDUM TO:** ☐ **PLAN OF TREATMENT** ☐ **MEDICAL UPDATE**

| 1. Patient's HI Claim No. | 2. SOC Date | 3. Certification Period From: To: | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| | | | | |

| 6. Patient's Name | 7. Provider Name |
|---|---|
| | |

| 8. Item No. | |
|---|---|
| | |

| 9. Signature of Physician | 10. Date |
|---|---|
| | |

| 11. Optional Name/Signature of Nurse/Therapist | 12. Date |
|---|---|
| | |

Form HCFA-487 (C4) (4-87) **PROVIDER**

# Appendix 8

## Instructions for the Completion of the Prior Authorization Request Form (PA/RF)

**ELEMENT 1 - PROCESSING TYPE**
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Use 999 - "Other" only if the requested category of service is not found in the list. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

* 120 - Home Health/Private Duty Nursing Services/Home Health Therapy/Respiratory Care Services/Personal Care Services -- Use this code if the recipient receives other home health services from your agency in addition to personal care.
121 - Personal Care Services -- Use this code if the recipient does not receive other home health services.
130 - Durable Medical Equipment
132 - Disposable Medical Supplies
999 - Other (use only if the requested category of service is not listed above)

* Includes PT, OT, Speech, and may include personal care provided by dually certified home health agencies

**ELEMENT 2 - RECIPIENT'S MEDICAID IDENTIFICATION NUMBER**
Enter the ***ten-digit*** recipient identification number as found on the recipient's Wisconsin Medicaid identification (ID) card.

**ELEMENT 3 - RECIPIENT'S NAME**
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medicaid ID card.

**ELEMENT 4 - RECIPIENT'S ADDRESS**
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included.

**ELEMENT 5 - RECIPIENT'S DATE OF BIRTH**
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medicaid ID card.

**ELEMENT 6 - RECIPIENT'S SEX**
Enter an "X" to specify male or female.

**ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS, AND ZIP CODE**
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

**ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER**
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider. If the performing provider phone number is different than the phone number of the billing provider, please include both phone numbers.

**ELEMENT 9 - BILLING PROVIDER'S MEDICAID PROVIDER NUMBER**
Enter the eight-digit Medicaid provider number of the billing provider.

**ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS**
Enter the appropriate *International Classification of Diseases, 9th Revision, Clinical Modification, Fourth Edition* (ICD-9-CM) diagnosis code and description most relevant to the recipient's current medical condition.

**ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS**
Enter the appropriate *International Classification of Diseases, 9th Revision, Clinical Modification, Fourth Edition* (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

**ELEMENT 12 - START DATE OF SPELL OF ILLNESS** (not required)

**ELEMENT 13 - FIRST DATE OF TREATMENT** (not required)

**ELEMENT 14 - PROCEDURE CODE(S)**
Enter the appropriate Revenue or HCPCS procedure code for each service/procedure/item requested, in this element. When the procedure may be one of two at any given time, request both procedure codes (W9045/W9046, W9930/W9940). Personal care-only agencies use W9900 for personal care worker (PCW) services. Dually certified home health agencies use W9903 for PCW services.

**ELEMENT 15 - MODIFIER** (not required)

**ELEMENT 16 - PLACE OF SERVICE**
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

| Code | Description |
|---|---|
| 0 | Other |
| 4 | Home [all personal care and travel time services are provided in the home, use POS 4] |

**ELEMENT 17 - TYPE OF SERVICE**
Enter the appropriate type of service code for each service/procedure/item requested.

| Numeric | Description |
|---|---|
| 1 | Medical (including: Home Health, Independent Nurses, PT, OT, ST, Personal Care, Respiratory Care) |
| 9 | Other (use only for DMS) |

**ELEMENT 18 - DESCRIPTION OF SERVICE**
Enter a written description corresponding to the appropriate Revenue, HCPCS, or National Drug Code (NDC) procedure code for each service/procedure/item requested.

When requesting home health services, indicate the number of visits per day/number of days per week times the total number of weeks being requested.

When requesting personal care services, indicate the number of hours per week times the total number of weeks being requested. The total hours requested on the PA/RF are required to match the total number of hours ordered by the physician. If requesting travel time, enter this as a separate item using procedure code W9902.

If sharing a case with another provider, enter "shared case with (name of other provider)" and include a statement that the total number of hours of all providers will not exceed the combined and total number of hours ordered on the PPOC.

When requesting two procedure codes to be used interchangeably (W9045/W9046), include a statement that the total number of hours will not exceed the combined total number of hours ordered on the PPOC.

When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits due to (number of) continuous hours of care."

**ELEMENT 19 - QUANTITY OF SERVICE REQUESTED**

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Home Health (number of visits)
Home Health Therapy-PT, OT, Speech (number of visits)
Personal Care (number of hours)
Private Duty Nursing (number of hours)
Respiratory Care Services (number of hours)

For home health services based on visits, providers are required to figure the quantity of visits as follows:

1. Total each procedure code separately.

2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)

   When one visit per day is requested, the actual number of days in the authorization period equals the total number of visits requested.

3. Divide the total number of days approved by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.

4. Calculate, for each code, the total number of days per week.

5. Multiply the total of visits approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

   Procedure code:

   W9930 - 1v/day, 3 days/week
   W9931 - 1v/day, 7 days/week

2. Total days requested:

   Start Date 06/05/99 End Date 12/31/99

   Total days requested = 200

3. Total weeks requested:

   200/7 = 28.6, round up to 29 weeks

4. Total services requested:

   W9930 - 3 visits per week x 29 weeks = 87 visits
   W9931 - 1 visit per day x 200 days = 200 visits

For private duty nursing, respiratory care, and personal care services based on hours, providers are required to figure the quantity of hours as follows:

1. Total each procedure code separately.

2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)

3. Divide the total number of days requested by seven to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.

4. Calculate, for each code, the total number of days per week.

5. Multiply the total of hours approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

   Procedure code:

   W9900 (or W9903) - 14hrs./week
   W9045 - 4hrs./day, 3 days/week
   W9046 - 7hrs./day, 7 days/week

2. Total days requested:

   Start Date 06/05/99 End Date 12/31/99

   Total days requested = 200

3. Total weeks requested:

   200/7 = 28.6, round up to 29 weeks

4. Total services requested:

   W9900 (or W9903) - 14 hours per week x 29 weeks = 406 hours
   W9045 - 4 hours per day, 3 days per week x 29 weeks = 348 hours
   W9046 - 7 hours per day x 200 days = 1,400 hours

**ELEMENT 20 - CHARGES**

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

***NOTE:*** The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Family Services.

**ELEMENT 21 - TOTAL CHARGE**
Enter the anticipated total charge for this request.

**ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT**
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medicaid Program payment methodology and Policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

**ELEMENT 23 - DATE**
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

**ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE**
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

In the blank space to the right of element 24, please indicate the start and end date for which services are being requested. If backdating is requested, specify backdating and indicate reason for need.

# Appendix 9

## Example of a Prior Authorization Request Form (PA/RF) for DMS

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 132

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 53723

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [x] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: ( XXX ) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI
53725

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: 343.9-Cerebral Palsy

11 DX: SECONDARY: 780.3-Severe Seizure Disorders

12 START DATE OF SOI:

13 FIRST DATE RX:

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| A6216 | | 4 | 9 | Gauze pad | 425 | XX.XX |
| K0411 | | 4 | 9 | Male external catheter | 42 | XX.XX |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | TOTAL CHARGE | 21 XXX.XX |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I.M. Requesting (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

Appendix

# Appendix 10

## Example of a Prior Authorization Request Form (PA/RF) for PRN Hours

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 121

| | |
|---|---|
| 2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890 | 4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow Anytown, WI 55555 |
| 3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A | |
| 5 DATE OF BIRTH: MM/DD/YY; 6 SEX: M ☐ F ☒ | 8 BILLING PROVIDER TELEPHONE NUMBER: ( XXX ) XXX-XXXX (YYY) YYY-YYYY |
| 7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: IM PC Agency 1 W. Williams Anytown, WI 55555 | 9 BILLING PROVIDER NO.: 87654321 |
| | 10 DX: PRIMARY: 344.0 quadraplegia |
| | 11 DX: SECONDARY: 599.0 urinary tract infection |
| | 12 START DATE OF SOI: N/A; 13 FIRST DATE RX: MM/DD/YY |

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| W9900 | | 1 | 1 | PCW 10 hr/wk X 52 wk | 520 | XXX.XX |
| | | | | and 3 hr PRN | 3 | |
| W9902 | | 4 | 1 | 2.5 hr/wk TT X 52 wk | 130 | XXX.XX |
| | | | | 1.5 hr TT PRN | 1.5 | XX.XX |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | TOTAL CHARGE | 21 XXX.XX |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY

23 MM/DD/YY (DATE) 24 I M Requesting RN (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

GRANT DATE | EXPIRATION DATE | PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED ***

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the Medicaid professional

DATE | CONSULTANT/ANALYST SIGNATURE

482-120

# Appendix 11

## Example of a Prior Authorization Request Form (PA/RF) for Personal Care and Home Health Services - Dually Certified Agency

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 120

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: ( XXX ) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider, 10 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654321
10 DX: PRIMARY: 401.9 - hypertension NOS
11 DX: SECONDARY: 250.0 - diabetes II (NIDDM)
12 START DATE OF SOI: N/A
13 FIRST DATE RX: MM/DD/YY

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| W9931 | | 4 | 1 | HHA initial visit | 24 | XXX.XX |
| | | | | 1 visit/day X 3 day/wk X 8 wk | | |
| W9903 | | 4 | 1 | PCW | 406 | XXX.XX |
| | | | | 14 hr/wk X 29 wk | | |
| W9902 | | 4 | 1 | 3.5 hr/wk TT X 29 wk | 101.5 | XXX.XX |
| | | | | | | |
| | | | | | | |
| | | | | | TOTAL CHARGE | 21 XXX.XX |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY

23 MM/DD/YY (DATE) 24 I M Provider RN (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED
[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

GRANT DATE | EXPIRATION DATE | PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED ***

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the Medicaid professional

DATE | CONSULTANT/ANALYST SIGNATURE

482-120

Appendix

# Appendix 12

## Example of a Prior Authorization Request Form (PA/RF) for Personal Care-Only Services - Shared Case

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 121

| | |
|---|---|
| 2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890 | 4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow<br>Anytown, WI<br>55555 |
| 3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A. | |
| 5 DATE OF BIRTH: MM/DD/YY | 6 SEX: M ☐ F ☒ X |
| 8 BILLING PROVIDER TELEPHONE NUMBER: ( XXX ) XXX-XXXX | |
| 7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:<br>I. M. Provider<br>10 W. Williams<br>Anytown, WI 55555 | 9 BILLING PROVIDER NO.: 87654321 |
| | 10 DX: PRIMARY: 401.9 - hypertension NOS |
| | 11 DX: SECONDARY: 250.0 - diabetes II (NIDDM) |
| | 12 START DATE OF SOI: N/A |
| | 13 FIRST DATE RX: MM/DD/YY |

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| W9900 (or W9903) | | 4 | 1 | PCW | 728 | XXX.XX |
| | | | | 14hr/wk X 52 wk | | |
| W9902 | | 4 | 1 | 3.5 hr/wk TT X 52 wk | 182 | XX.XX |
| | | | | | | |
| | | | | Shared Case with "Me-Too-Provider" | | |
| | | | | Total hr for all providers will not | | |
| | | | | exceed total hr on POC | | |
| | | | | | TOTAL CHARGE | 21 XXX.XX |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY

23 MM/DD/YY (DATE) 24 I M Provider RN (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE | EXPIRATION DATE

PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED: ***

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the Medicaid professional

DATE | CONSULTANT/ANALYST SIGNATURE

482-120

# Appendix 13

## Example of a Prior Authorization Request Form (PA/RF) for Personal Care-Only Services by One Provider

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 121

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: DD/MM/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: ( XXX ) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I. M. Provider
10 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 429.2 - CVA

11 DX: SECONDARY: 250.0 - diabetes II (NIDDM)

12 START DATE OF SOI: N/A

13 FIRST DATE RX: MM/DD/YY

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| W9900 (or W9903) | | 4 | 1 | PCW | 728 | XXX.XX |
| | | | | 14 hr/wk x 52 wk | | |
| W9902 | | 4 | 1 | 3.5 hr/wk TT X 52 wk | 182 | XXX.XX |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | TOTAL CHARGE | 21 | XXXX.XX |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY

23 MM/DD/YY (DATE) 24 J M Provider RN (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED ***

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the Medicaid professional

DATE _____ CONSULTANT/ANALYST SIGNATURE _____

482-120

# Appendix 14

## Prior Authorization Checklist

Use this as a "last minute check-list" to ensure that you have the correct documentation included with your prior authorization (PA) request and in your records.

*Avoid clerical returns. Make sure the:*

- ✓ Medicaid provider number is correct.
- ✓ Entire billing address is completed.
- ✓ **Recipient's Medicaid ID (**10 digits**) number is correct.**
- ✓ Total charges (Element 21 on the PA/RF) are included. Use your usual and customary fee.
- ✓ Requested start date is on the PA/RF to the right of the provider signature.
- ✓ Required forms and attachments are all included.

| New Requests | Renewal Requests | Amendments |
|---|---|---|
| 1) PA/RF<br>2) HCAF<br>3) 485/Physician Orders | 1) PA/RF<br>2) HCAF - OR, Update with attachments<br>3) 485/Physician Orders | 1) Amendment Form<br>2) Copy of Original PA/RF<br>3) Updated physician's orders/Plan of Care<br>4) HCAF OR Update with attachments |

PA/RF: Prior Authorization Request Form

485: HCFA 485 – Health Care Financing Administration form #485 - Physician Plan of Treatment

HCAF: Wisconsin Medicaid Home Care Assessment Form

Update: Update to the Wisconsin Medicaid Home Care Assessment Form

Attachments: Any pages of the HCAF that document any changes in the recipient's condition. The calendar in Element 12.1 showing the increase or decrease in hours should be included.

# Appendix 15

## Instructions for the Completion of the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA)

The following instructions are for **personal care providers** using the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) form to request prior authorization for **disposable medical supplies**. The timely determination of authorization is significantly enhanced by the completenes and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

Medicaid Prior Authorization Unit
Suite 88
6406 Bridge Rd.
Madison, WI 53784-0088

Questions regarding completion of the PA/RF and/or the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) may be addressed to Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883.

**RECIPIENT INFORMATION:**

**ELEMENT 1 - RECIPIENT'S LAST NAME**
Enter the recipient's last name exactly as it appears on the recipient's Wisconsin Medicaid identification card.

**ELEMENT 2 - RECIPIENT'S FIRST NAME**
Enter the recipient's first name exactly as it appears on the recipient's Wisconsin Medicaid identification card.

**ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL**
Enter the recipient's middle name exactly as it appears on the recipient's Wisconsin Medicaid identification card.

**ELEMENT 4 - RECIPIENT'S MEDICAID NUMBER**
Enter the ***ten-digit*** recipient identification number as found on the recipient's Wisconsin Medicaid identification card.

**ELEMENT 5 - RECIPIENT'S AGE**
Enter the age of the recipient in numeral form (i.e., 45, 60, 21, etc.).

**PROVIDER INFORMATION:**

**ELEMENT 6 - PRESCRIBING PHYSICIAN'S NAME**
Enter the name of the prescribing physician in this element.

**ELEMENT 7 - PRESCRIBING PHYSICIAN'S MEDICAID PROVIDER NUMBER**
Enter the eight-digit Wisconsin Medicaid provider number of the physician prescribing the item(s) of disposable medical supplies (DMS).

**ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER**

Enter the telephone number, including area code, of the provider dispensing the requested DMS item(s).

The remaining portions of this attachment are to be used to document the justification for the requested DMS item(s).

1. Complete elements A through H and J for all items of DMS requested.
2. Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid.
3. Read the Prior Authorization Statement before dating and signing the attachment.
4. The attachment must be dated and signed by the provider requesting/dispensing the item(s).

# Appendix 16

## Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) Form

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
5406 Bridge Road
Madison, WI 53784-0088

**PA/DMEA**

**PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT**

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

**RECIPIENT INFORMATION**

① LAST NAME ② FIRST NAME ③ MIDDLE INITIAL ④ MEDICAL ASSISTANCE ID NUMBER ⑤ AGE

**PROVIDER INFORMATION**

⑥ PRESCRIBING PHYSICIAN'S NAME ⑦ PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER ⑧ ( ) DISPENSING PROVIDER'S TELEPHONE NUMBER

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

C. Is the recipient able to operate the equipment/item requested — ☐ Yes ☐ No — If not, who will do this?

D. Is training provided or required? ☐ Yes ☐ No Explain.

E. State where equipment/item will be used:
☐ Home (Describe type of dwelling and accessibility)

☐ Nursing Home ☐ School ☐ Office ☐ Job
(Describe accessibility and any special needs)

F. Attach an Occupational or Physical Therapy Report if available.

G. State estimated duration of need.

H If renewal or continuation of DME Authorization is requested, describe the recipient's
- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

I. Indicate amount of oxygen to be administered:

| | |
|---|---|
| ____ Liters per minute | ____ Continuous |
| ____ Hours per day | ____ PRN |
| ____ Days per week | ____ $PaO_2$ |

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by EDS

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J ____ ____
Date

____
Requesting Provider's Signature

# Appendix 17
## Instructions for Completion of the Prior Authorization Amendment Request Form

| | |
|---|---|
| (1) DATE | Enter today's date in MM/DD/YY format. |
| (2) PREVIOUS PA # | Enter the seven-digit prior authorization request number from the PA/RF form to be amended. The request number is located at the top center section of the PA/RF form. |
| (3) RECIPIENT NAME | Enter the recipient's name as indicated in Element 3 on the PA/RF form. |
| (4) RECIPIENT MA # | Enter the ten-digit recipient Medicaid identification number as indicated on the PA/RF form. |
| (5) PROVIDER NAME | Enter the billing provider name and address as indicated in Element 7 on the PA/RF form. |
| (6) PROVIDER # | Enter the eight-digit billing provider number as indicated in Element 9 on the PA/RF form. |
| (7) AMENDMENT EFFECTIVE DATE | Enter the dates that the requested amendment (i.e., the date the amended services will be provided) should start ("FROM") and end ("TO"). |
| (8) REASON(S) FOR AMENDMENT REQUEST | Enter the reason(s) for requesting additional service(s) for the recipient. When service is being reduced or discontinued, please clearly indicate the type of service and the date the service is being reduced or discontinued. |
| (9) PROCEDURE CODES | Enter the appropriate procedure code and hours per day, days per week, multiplied by the number of weeks for each service. Show only the additional services being requested, not the revised total of services being requested. |
| (10) SIGNATURE/DATE | The signature of the provider requesting this amendment and the date of the request must appear in this element. |

***NOTE:*** Complete the amendment form and include all of the following:

1. Copy of the original PA/RF to be amended.
2. Updated physician's orders/plan of care.
3. New Home Care Assessment Form (HCAF) or updated HCAF. Update is required to include copies of any pages showing changes, including calendar - 12.1 and assessment changes.

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

# Appendix 18

## Prior Authorization Amendment Request Form

Wisconsin Medicaid Prior Authorization Request

Mail To:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

1. Complete this form and attach:
   a. A copy of the original Prior Authorization Request Form.
   b. Updated physician's orders/plan of care.
   c. Home Care Assessment Form OR Update (for PCW requests).
2. Mail toWisconsin Medicaid.

| 1) Date: | 2) Previous Prior Authorization Number: | |
|---|---|---|
| 3) Recipient Name: | 4) Recipient Medicaid ID Number: | |
| 5) Billing Provider Name and Address: | 6) Billing Provider Number: | 7) Amendment Effective Date:<br>FROM:<br><br>TO: |

8) Reason(s) for Amendment Request:

9) Indicate procedure(s) to be amended by hours/visits per day, days per week, multiplied by the number of weeks.

RN _____

LPN _____

HHA _____

PT _____

OT _____

ST _____

PCW _____

OTHER _____

10) _____ _____
Signature Date

# Appendix 19

## Example of Prior Authorization Amendment Request Form

Wisconsin Medicaid Prior Authorization Request

Mail To:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

1. Complete this form and attach:
   a. A copy of the original Prior Authorization Request Form.
   b. Updated physician's orders/plan of care.
   c. Home Care Assessment Form OR Update (for PCW requests).
2. Mail to Wisconsin Medicaid.

| 1) Date: MM/DD/YY | 2) Previous Prior Authorization Number: 7654321 | |
|---|---|---|
| 3) Recipient Name: Recipient, Ima A. | 4) Recipient Medicaid ID Number: 1234567890 | |
| 5) Billing Provider Name and Address: I. M. Billing, 1 W. Williams, Anytown, WI 55555 | 6) Billing Provider Number: 87654321 | 7) Amendment Effective Date: FROM: 2/15/99 TO: 5/13/99 |

8) Reason(s) for Amendment Request:

On 1/15/99, client had a CVA with L sided weakness. She is able to ambulate with a quad cane and is safe alone with Lifeline, but requires more assistance with ADLs. Please see revised relevant assessments.

Request 1 hr/day x 7 days/wk in addition to the hours already provided.

9) Indicate procedure(s) to be amended by hours/visits per day, days per week, multiplied by the number of weeks.

RN _____

LPN _____

HHA _____

PT _____

OT _____

ST _____

PCW W9903 Add 1 hr/day, 7 days/wk X 14 weeks

OTHER W9902 1hr/day TT X 7 days

10) I.M. Requesting, RN (Signature) 02/15/99 (Date)

# Appendix 20

## Example of Prior Authorization Amendment Request Form Showing Discharge From Services

Wisconsin Medicaid Prior Authorization Request

Mail To:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

1. Complete this form and attach:
   a. A copy of the original Prior Authorization Request Form.
   b. Updated physician's orders/plan of care.
   c. Home Care Assessment Form OR Update (for PCW requests).
2. Mail to Wisconsin Medicaid.

| 1) Date: MM/DD/YY | 2) Previous Prior Authorization Number: 7654321 | |
|---|---|---|
| 3) Recipient Name: Recipient, Ima A. | 4) Recipient Medicaid ID Number: 1234567890 | |
| 5) Billing Provider Name and Address: I. M. Billing, 1 W. Williams, Anytown, WI 55555 | 6) Billing Provider Number: 87654321 | 7) Amendment Effective Date: FROM: 5/11/99 TO: 9/24/99 |

8) Reason(s) for Amendment Request:

Recipient discharged from services on 9-24-99 due to (please specify reason recipient was discharged. Example: personal care services no longer needed, change of providers, family resuming care, etc.)

9) Indicate procedure(s) to be amended by hours/visits per day, days per week, multiplied by the number of weeks.

RN _____

LPN _____

HHA _____

PT _____

OT _____

ST _____

PCW _____

OTHER _____

10) I.M Requesting, RN _____ 09/20/99 _____
Date

# Glossary of Common Terms

**Adjudication**
Adjudication is when Wisconsin Medicaid makes a determination on a prior authorization request.

**Backdating**
Backdating occurs when prior authorization (PA) is given for effective dates prior to the PA request being received by the Wisconsin Medicaid fiscal agent.

**Department of Health and Family Services (DHFS)**
The Wisconsin Department of Health and Family Services administers Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

**Disposable medical supplies (DMS)**
Disposable medical supplies are medically necessary items, which have a very limited life expectancy and are consumable, expendable, disposable, or nondurable.

**Dually certified**
An agency that is Medicaid-certified to provide both home health and personal care services is dually certified.

**Licensed practical nurse (LPN)**
A licensed practical nurse is a person who is licensed in Wisconsin as a practical nurse under ch. 441, Wis. Stats., or, if practicing in another state, is licensed as a practical nurse by that state.

**Medical necessity**
Medical necessity is a medical assistance service under ch. HFS 107, Wis. Admin. Code, that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability, and:
(b) Meets the following standards:
1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability.
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided.
3. Is appropriate with regard to generally accepted standards of medical practice.
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient.
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature.
6. Is not duplicative with respect to other services being provided to the recipient.
7. Is not solely for the convenience of the recipient, the recipient's family or a provider.
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service, which is reasonably accessible to the recipient.
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

**Medicare**
Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

**Part-time, intermittent skilled nursing and therapy services**
Skilled nursing and therapy services provided in the home for less than eight hours in a calendar day are part-time, intermittent.

**Personal care worker (PCW)**
A personal care worker is an individual employed by a personal care provider certified under HFS 105.17, Wis. Admin. Code, or under contract to the personal care provider to provide personal care services under the supervision of a registered nurse.

**Plan of Care (POC)**
A written plan of care for a recipient is developed by a registered nurse based on physician orders in collaboration with the recipient/family, and approved by the physician. The purpose of the POC is to provide necessary and appropriate services, allow appropriate assignment of a PCW, set standards for personal care activities, and give full consideration to the recipient's preferences for service arrangements and choice of PCWs. The POC is based on a visit to the recipient's home and includes a review and interpretation of the physician's orders; evaluation of the recipient's needs and preferences;

assessment of the recipient's social and physical environment, including family involvement, living conditions, the recipient's level of functioning and any pertinent cultural factors such as language; and the frequency and anticipated duration of service.

**Prior authorization (PA)**
Prior authorization (PA) is approval of coverage of Wisconsin Medicaid services granted by the Department of Health and Family Services (DHFS) before the provision of the services.

**Private duty nursing (PDN)**
Private duty nursing is a service provided by a registered nurse (RN) or licensed practical nurse (LPN) to a recipient who requires eight or more hours of skilled nursing care in a calendar day, as specified in HFS 107.12, Wis. Admin. Code.

**PRN (from the latin term *pro re nata*)**
PRN hours are "as needed" hours, which may be requested when there is a reason to expect a deviation from the typical weekly schedule of staffing as documented on the Home Care Assessment Form.

**Provider**
A personal care provider is a home health agency, county department, independent living center, tribe, or public health agency that has been certified by Wisconsin Medicaid to provide personal care services to recipients and to be reimbursed by Wisconsin Medicaid for those services.

**Registered nurse (RN)**
A registered nurse is a person who holds a current Wisconsin certificate of registration as a registered nurse under ch. 441, Wis. Stats., or, if practicing in another state, is registered with the appropriate licensing agency in that state.

**Respiratory care services (RCS)**
The treatment of a person who receives mechanically assisted respiration is a respiratory care service.

**Supervision**
Supervision of personal care services is required to be performed by a qualified RN who reviews the Plan of Care (POC), evaluates the recipient's condition, and observes the PCW performing assigned tasks at least every 60 days. Supervision requires intermittent face-to-face contact between supervisor and assistant and regular review of the assistant's work by the supervisor according to HFS 101.03(173), Wis. Admin. Code. Supervisory review includes:

- A visit to the recipient's home.
- Review of the PCWs daily written record.
- Discussions with the physician of any necessary changes in the POC, according to HFS 107.112(3)(c), Wis. Admin. Code.